Chapter XV

MBC'S DIVERSION PROGRAM

A. General Description of Functions

This chapter addresses the Medical Board's Diversion Program, which "diverts" substance-abusing physicians out of the enforcement program described in the preceding fourteen chapters and into a program that is intended to monitor them while they attempt to recover from the disease of addiction.[377] The Diversion Program designs a contract that includes terms and conditions of participation for a five-year monitoring period, including random bodily fluids testing, required group meeting attendance, required worksite monitoring, and often substance abuse treatment and/or psychotherapy. Those who comply with the terms and conditions of their Diversion Program contract may be "successfully terminated" from the Program after three years of continuous sobriety. Those who violate the terms and conditions of their Diversion Program contract may be "unsuccessfully terminated" from the Program and referred to the enforcement program for disciplinary action. During their participation in the Program, these physicians generally retain their full and unrestricted license to practice medicine, and many of them are in fact permitted to practice medicine subject to the terms and conditions of their contracts. Many of them participate in absolute confidentiality — their participation in the Diversion Program is secreted from the Board's enforcement program, their patients, and the public.

It is important to understand that the Diversion Program is a *monitoring* program, not a treatment program. It does not provide substance abuse treatment; its staff are not authorized or trained to do so. Instead, it evaluates the needs of its participants; provides a rehabilitative plan that directs them to treatment — including inpatient detoxification, medical and psychiatric evaluation, and psychotherapy, as appropriate; monitors their compliance with the terms and conditions of their

[377] The enabling act of the Diversion Program also refers to physicians with "impairment due to . . . mental illness or physical illness." Bus. & Prof. Code § 2340. However, the Diversion Program has historically and primarily been structured to monitor substance-abusing physicians (or physicians who are "dually diagnosed" with both chemical dependency and mental illness). Despite the inclusion of the terms "mental illness and physical illness" in its enabling act, the Diversion Program was not authorized to "divert" singly-diagnosed mentally ill physicians until January 1, 2003, when an amendment included in SB 1950 (Figueroa) became effective. Thus, for most of its history, the Diversion Program has been structured primarily to monitor chemically dependent physicians, and this chapter focuses on that function.

contract with the Program; and is authorized to terminate them from the Program (and refer them to the enforcement program) if they do not comply.

Supporters argue that the Diversion Program protects the public by providing impaired physicians with access to appropriate intervention programs and treatment services, and monitoring them for several years to ensure they have recovered and are consistently capable of safe practice. According to Dr. Gene Feldman, who was president of the Medical Board during 1980 when the Program was created, "the Diversion Program was enacted because a lot of doctors who came before us in discipline had hurt no one but themselves through the disease of substance abuse/chemical dependency. They were being disciplined at an average cost of $30,000 per case, and most had already gone into rehabilitation programs and were clean and sober. But we were required to discipline them and ruin their lives."[378] Dr. Feldman and others envisioned the Program as being cheaper than discipline and more protective of the public, in that it could immediately remove an impaired physician from practice if necessary (whereas the discipline system at that time lacked any meaningful interim remedies).

As discussed briefly in Chapter V,[379] the Diversion Program is a "stand-alone" program that is relatively isolated within the structure and management of the Medical Board. Because it is so distinct and separate from the enforcement program described in the prior chapters, this chapter is structured differently to provide the reader with an in-depth understanding of the Program and its purpose, history, structure, personnel, participants, and problems.

B. Authority and Methodology of the MBC Enforcement Monitor

Enforcement Monitor's duty to evaluate the diversion program. Business and Professions Code section 2220.1(c)(2) requires that, as part of its evaluation of MBC's overall enforcement program, "[t]he enforcement program monitor shall also evaluate the effectiveness and efficiency of the board's diversion program and make recommendations regarding the continuation of the program and any changes or reforms required to assure that physicians and surgeons participating in the program are appropriately monitored and the public is protected from physicians and surgeons who are impaired due to alcohol or drug abuse or mental or physical illness."

This assignment is timely and overdue. Despite the critical importance of the proper functioning of the Diversion Program in protecting the public from impaired physicians who retain their licenses to practice medicine, the Diversion Program has not been externally audited since 1986.

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[378] Presentation by Dr. Gene Feldman at DMQ's July 27, 1994 meeting, recorded in 14:4 CAL. REG. L. REP. (Fall 1994) at 65.

[379] *See* Ch. V.B.3.

Enforcement Monitor's methodology in evaluating the Diversion Program. The Enforcement Monitor team read and studied both the current and prior versions of the Diversion Program's statutes (Business and Professions Code section 2340 *et seq*.) and regulations (section 1357.1 *et seq*., Title 16 of the California Code of Regulations). In addition, the Monitor studied two internal policy and procedure manuals that guide the day-to-day operation of the Program: (1) the *Diversion Program Manual*, which — at the time of its provision to the Monitor in November 2003 — had not been comprehensively updated since 1998; and (2) the *Diversion Program Policy, Guidelines, and Procedures*, a supplemental compilation of policies and procedures implemented by Diversion Program staff since the *Diversion Program Manual*'s last comprehensive update in 1998, and prepared especially for the Monitor.

The Monitor also read and summarized all prior available audits and evaluations of the Diversion Program, including three Auditor General audits, the CHP report released in January 1993, and the State Auditor's 1995 report; all of these critiques are described below. In addition, the Monitor team reviewed the Medical Board's *Annual Report* for the past 15 years for its data on Diversion Program participation and cost; the Diversion Program's own annual reports from 1994 through 2000; and the Center for Public Interest Law's vast library of Diversion Program documents that have been distributed to the Medical Board, its Division of Medical Quality, and/or its various diversion committees and collected by CPIL as part of its monitoring function since at least 1993.

In an attempt to determine whether the Program is functioning in compliance with its statutes, regulations, and the policies and procedures set forth in its internal manuals, the Monitor team analyzed a sample of participant files[380] in three major areas:

- ***Intakes***: Commencing in March 2004, we analyzed the files of the twenty (20) most recent Diversion Program "intakes," physicians who have (a) self-referred into the Program, or (b) are participating via a statement of understanding (SOU) because a complaint was pending against them at the time they sought admission, or (c) because they were ordered by the Division of Medical Quality to participate in the Program as a term of probation.

[380] Diversion Program participant files are accorded extraordinary confidentiality: Only Diversion Program staff and members of the DECs know the identity of participants in the Diversion Program. Other MBC staff (including Enforcement Program staff) have no access to the identities or files of Diversion Program participants; nor do members of the Medical Board or the Liaison Committee to the Diversion Program. However, both state and federal law waive the confidentiality normally accorded Diversion Program files (and treatment records possibly contained therein) for "qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation," so long as those personnel do not "identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner." *See* 42 U.S.C. § 290dd-2(b)(2)(B); 42 C.F.R. § 2.1(b)(2)(B); Health and Safety Code § 11977(c)(3).

- ***Relapses***: We also looked at the files of twenty (20) participants who relapsed into drug or alcohol use during the past few years. We identified these cases from the "Quarterly Quality Review" reports that are distributed to the Board's Diversion Committee at each quarterly committee meetings, and analyzed these participants' pre-relapse history and the Program's response to the relapse.

- ***Imminent completions***: Finally, we looked at the files of twenty (20) participants who have been in the Program for approximately five years and who are on the verge of achieving three years of sobriety such that they will soon "successfully complete" the Program.

In addition to reviewing these case files and collecting data from them, we have extensively interviewed the Diversion Program Administrator and other staff of the Program. We also interviewed the Liaison Committee to the Diversion Program.

As a result of this review, the Monitor has detected numerous significant problems in the functioning of the Diversion Program. These issues are discussed below in Chapter XV.G. To put those concerns into perspective, however, it is instructive to review the statutory purpose of the Diversion Program; its structure, staffing, and funding; the actual functioning of the Program; and prior critiques of the Program.

C. Statutory Purpose of the Diversion Program

The Medical Board's Diversion Program was created in 1980 legislation that enacted Business and Professions Code section 2340 *et seq*. In the enabling legislation, the Legislature stated its intent "that the Medical Board of California seek ways and means to identify and rehabilitate physicians and surgeons with impairment due to abuse of dangerous drugs or alcohol, or due to mental illness or physical illness, affecting competency so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety."[381] This language thus requires the Board to "identify and rehabilitate" impaired physicians and "return" them to the practice of medicine, but only if this can be done "in a manner which will not endanger the public health and safety."

Subsequent legislative actions confirm this interpretation. Business and Professions Code section 2229 was amended in SB 2375 (Presley) (Chapter 1597, Statutes of 1990), extensive reform

[381] Bus. & Prof. Code § 2340.

legislation that followed the release of *Code Blue* and the *Klvana* prosecution.[382] SB 2375 amended section 2229(a) to clarify that "protection of the public shall be the highest priority" for the Medical Board of California in exercising its disciplinary authority. SB 2375 also addressed the relative role of "rehabilitation," which is one goal of the Diversion Program. The bill amended section 2229(c) to unambiguously state: "Where rehabilitation and protection are inconsistent, protection shall be paramount." Finally, AB 269 (Correa) (Chapter 107, Statutes of 2002) added section 2001.1 to the Business and Professions Code, which reiterates that "[p]rotection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

D. The Structure, Staffing, and Funding of the Diversion Program

The Medical Board of California's Diversion Program is one of the few state-sanctioned impaired physician programs to be run from within a state medical licensing board by employees of that board. Most other state medical boards contract out all functions of their impaired physician programs to the private sector.[383] And most other California occupational licensing agencies whose statutes provide for a diversion program contract with a private company to administer those programs.[384] As described below, MBC's Diversion Program contracts out some components of its program, including its drug testing, laboratory, and group meeting components. But the critical case management component and all aspects of the Diversion Program's management and administration are performed by employees of the Medical Board — and have been since the Program's inception in 1981.

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[382] *See supra* Ch. IV.B. and VI.C.

[383] According to the Federation of State Physician Health Programs, only four state physician diversion programs are operated solely by the state medical board. Most state medical boards contract the operation of their diversion programs to state medical societies or independent corporations. Information on the operation of state physician diversion programs is found at www.ama-assn.org/ama/pub/category/5705.html.

[384] We found eight other California agencies with diversion programs for their licensees. Seven of the eight (including the Dental Board of California, the Board of Registered Nursing, the Board of Pharmacy, the Physical Therapy Board of California, the Physician Assistant Committee, the Veterinary Medical Board of California, and the Osteopathic Medical Board of California) arrange for all operations of their diversion programs to be administered by a private company that is under contract with the Department of Consumer Affairs. Only the State Bar — which recently created a new diversion program for substance-abusing and mentally ill attorneys called the "Lawyer Assistance Program," which is modeled after the Medical Board's operational structure — operates its attorney diversion program in-house. See SB 479 (Burton), Cal.Stats.2001 c.129, enacting Bus. & Prof. Code § 6230 *et seq*.

The Program is staffed by ten MBC employees: (1) a Diversion Program Administrator[385] based in Sacramento; (2) five "case managers" (CMs)[386] based in Sacramento, Bakersfield, Fresno, the Bay Area, and Orange County; and (3) four support staff based in Sacramento, including a Collection System Manager (CSM) with responsibility for overseeing the Program's urine collection and testing system — the Program's major objective measure of compliance with Diversion contracts. The CSM is required to generate a monthly list of random dates on which each participant will be tested; forward that list to local urine collectors (see below); ensure that samples are collected pursuant to the random schedule; ensure that samples are sent promptly to an approved laboratory for testing; ensure that results are received from the lab and forwarded to the CMs of tested participants; and ensure that results are appended to participants' files in the Program's Diversion Tracking System.

These ten Board employees are assisted by thirteen "group facilitators" (GFs) based throughout the state.[387] GFs facilitate biweekly group meetings of Diversion Program participants in their localities. They are expected to conduct group meetings, record attendance, observe each participant for any sign of substance abuse or pre-relapse behavior, take random urine tests if noncompliance is suspected, and report problems to the CMs and to Program management. GFs are not state employees, such that there is no formal duty statement or minimum qualifications for them.[388] They sign a "memorandum of understanding" with the Diversion Program, and they are paid directly by Program participants for the meeting facilitation services they provide.

The Program is also assisted by approximately 30 local businesses throughout the state that serve as urine specimen collectors for the Diversion Program. Pursuant to a random schedule generated by the Collection System Manager, these collectors are expected to conduct observed urine collections on the dates specified and to immediately transmit urine samples to a Program-approved laboratory for testing (following chain of custody procedures), submit a monthly report of all tests

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[385] The State Personnel Board's minimum qualifications for the Diversion Program Administrator position do not require a college degree, certification as a drug/alcohol counselor, or a license to practice counseling, social work, therapy, or medicine. They do require at least one year of responsible experience in "substance abuse treatment or prevention, rehabilitation, or education."

[386] The State Personnel Board's title for a Diversion Program case manager is "Diversion Program Compliance Specialist I." The minimum qualifications for this position do not require a college degree, certification as a drug/alcohol counselor, or a license to practice counseling, social work, therapy, or medicine. They do require at least two years of experience "performing analytical staff work and/or clinical counseling work in a substance abuse treatment or prevention program."

[387] Currently, GFs conduct group meetings of Diversion Program participants in Culver City, Fresno, Sacramento, Santa Barbara, Santa Cruz, Eureka, Modesto, Santa Rosa, the Bay Area, San Diego, Chico, Huntington Beach, and San Bernardino.

[388] Although there are no required minimum qualifications for GFs, the Program seeks licensed therapists or certified drug/alcohol abuse counselors. Most Diversion Program GFs in fact have a license.

taken, and document any problems or incidents in the taking of a sample. These collectors are not state employees, such that there is no formal duty statement or minimum qualifications for them. There is no contract, memorandum of understanding, or any other type of formal agreement between the Diversion Program and these independent businesses. They are recruited by the GFs and CMs and approved by the Program Administrator, and Program participants are required to utilize their services. They are paid directly by Program participants.

As described in Chapter V, the Diversion Program maintains the Diversion Tracking System (DTS), its own separate database of information on its participants that is unavailable to Board management or the enforcement program. DTS is supposed to contain a file on each participant that includes all information on the participant, the terms and conditions of his/her Diversion Program contract (including restrictions on medical practice), and his/her participation in the Diversion Program, including results of all bodily fluids testing (which are downloaded directly into DTS from the laboratory that tests participants' urine samples), absences from required group meetings, and dates of worksite monitor and treating therapist reports.

As of June 30, 2004, 258 physicians were admitted to and participating in the Diversion Program.[389] In fiscal year 2003–04, the Diversion Program cost over $1 million. That cost was subsidized entirely through license fees paid by all California physicians. Participants in MBC's Diversion Program pay nothing toward the overhead costs of the Program.[390] They are required to pay the costs of their own drug testing (approximately $220 per month during the first two years[391]) and group meetings (as of May 2004, $322 per month for two meetings per week[392]), for a total of $542 per month. Additionally, if they are required to undergo substance abuse treatment as a condition of Diversion Program participation, they must pay for that treatment.[393]

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[389] In addition to its 258 active participants, the Program was also monitoring 29 prospective participants who had signed an "interim agreement" (see below) but had not yet seen a DEC or signed a formal Diversion Program Agreement; and 17 California physicians participating in other-state diversion programs.

[390] Dentists and dental auxiliaries in the Dental Board's "Impaired Licentiates Program" pay $72.50 per month toward the overhead costs of the Program. Pharmacists in the Board of Pharmacy's "Pharmacists Recovery Program" pay $75.00 per month toward the overhead costs of the Program. Nurses in the Board of Registered Nursing's Diversion Program pay $25.00 month in overhead costs. Both the State Bar and the Veterinary Medical Board are authorized to charge overhead fees to program participants; they have not done so.

[391] Participants currently pay $20 to the collector for each observed collection, and $35 for laboratory testing of the sample, for a total of $55 per test. During the first two years of participation, participants are generally tested four times per month; thus, participants pay approximately $220 per month for drug testing during the first two years.

[392] At its May 2004 meeting, the Diversion Committee and DMQ approved an increase in group facilitator fees, from $315 per month for two meetings per week (or $220 per month for one meeting per week) to $322 per month for two meetings per week (or $225 for one meeting per week).

[393] According to Program staff, inpatient substance abuse treatment ranges from $8,000–$20,000, and is not always covered by insurance.

E. Overview of Participation in the Diversion Program

A physician makes contact with the Diversion Program in one of three ways: (1) he may telephone the Diversion Program at its Sacramento headquarters office seeking information and/or admission into the Program (a so-called "self-referral"); (2) impaired physicians are sometimes detected through complaints or reports made to the enforcement program, and enforcement permits the physician to enter Diversion under a "statement of understanding" (SOU)[394] (these physicians are called "diverted" or "Board-referred" participants); or (3) the Board may order a physician to participate in Diversion as a term of probation in a public disciplinary order ("Board-ordered participants").

Regardless of why the physician is entering the Program, a Program analyst conducts a telephone interview to record basic information about the physician's situation. The analyst checks the enforcement program's CAS computer system to determine whether any complaints are pending against the physician; if not,[395] the analyst relays the information on the prospective participant to the CM with responsibility for covering the geographical area of the state in which the physician lives. Within the next four days, the CM telephones the physician, assesses the situation, and schedules an in-person "intake interview" which should occur within seven days of the physician's initial contact with the Program.[396] At the intake interview, the physician must sign an "interim agreement" with the Program.[397] At this point, the CM is required to do three things: (1) arrange for a comprehensive multidisciplinary physical and mental evaluation of the prospective participant by

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[394] *See* Bus. & Prof. Code § 2350(b).

[395] If there is a complaint pending against a physician who seeks admission into the Diversion Program, the Program asks the Deputy Chief of Enforcement to "divert" the physician into Diversion. If the complaint is based primarily on "the self-administration of drugs or alcohol under Section 2239, or the illegal possession, prescription, or nonviolent procurement of drugs for self-administration, and does not involve actual harm to the public or [the physician's] patients," the Deputy Chief "shall refer" the physician to Diversion for an evaluation of eligibility. However, before making the referral, enforcement may require the physician to sign a "statement of understanding" (SOU) in which the physician agrees that "violations of this chapter or other statutes that would otherwise be the basis for discipline may nevertheless be prosecuted should the physician . . . be terminated from the program for failure to comply with program requirements." Bus. & Prof. Code § 2350(b).

[396] These timeframe goals are not stated in any statute, regulation, or procedure manual. They are set forth in the Diversion Program's "Quarterly Quality Review" reports that are reviewed by the Diversion Committee at its quarterly meetings.

[397] In the interim agreement, the physician acknowledges that he is applying for admission into the Diversion Program, recognizes that he may have a substance abuse disorder, and agrees to restrict or cease practice if so instructed by the Diversion Program; enter a treatment program if so instructed by the Diversion Program; undergo a minimum of four observed urine tests per month; attend facilitated group meetings with other Diversion Program participants; attend additional group meetings of Alcoholics Anonymous or Narcotics Anonymous, as instructed by the Diversion Program; abstain from the use of alcohol and drugs except those that have been prescribed by another physician and approved by the Diversion Program; refrain from self-prescribing any medications that require a prescription; and immediately report to the Program any relapse or use of alcohol or unauthorized drugs.

a physician who specializes in addiction medicine and is competent to recommend the type of treatment and monitoring needed by the prospective participant;[398] (2) refer the physician to a local GF who conducts weekly group therapy meetings attended by other impaired physicians who are participating in the Diversion Program, so that the physician may begin to attend meetings pending his formal admission into the Program; and (3) arrange for random urine testing of the physician commencing immediately.

Once the physician's comprehensive evaluation has been completed, the results and recommendations are forwarded to the CM, who then refers the physician's file to a local Diversion Evaluation Committee (DEC) and schedules the physician for an in-person appointment with the DEC. The Diversion Program maintains five DECs throughout the state; by statute,[399] each DEC consists of five individuals (three physicians and two non-physicians) who have expertise in substance abuse detection and treatment. DEC members are private parties appointed by DMQ.[400] DECs meet quarterly and in private.[401] The DEC reviews the file, meets with the physician, and makes a recommendation to the Diversion Program Administrator whether the physician should be accepted into the Program, whether the physician should be permitted to continue practicing medicine, and the terms and conditions of the physician's Diversion Program contract (including proposed treatment requirements). The DEC acts in an advisory role to the Program Administrator.[402] The Program Administrator prepares a formal Diversion Program contract, and — if the physician signs it — he is formally accepted into the Program.

The time period from the initial contact by the physician with the Program to the DEC meeting and signature on the formal contract generally exceeds three months. In the meantime, the participant is expected to attend two group meetings per week and is subject to four random urine tests per month during the first 24 months of participation.[403] If the participant is permitted to

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[398] Business and Profession Code section 2350(h) requires DMQ to "establish criteria for the selection of evaluating physicians and surgeons or psychologists who shall examine physicians and surgeons requesting diversion . . . ." In 1981, DMQ adopted the following regulation: "A physician selected by the program manager or his/her designee to conduct medical and psychiatric evaluations of an applicant shall be a licensed physician who is competent in his/her field of specialty." 16 CAL. CODE REGS. § 1357.3.

[399] Bus. & Prof. Code § 2342.

[400] *Id*.

[401] *Id*. at § 2353.

[402] *Id*. at § 2344.

[403] These rules governing random urine testing and group meeting attendance do not appear in any statute, regulation, or even the *Diversion Program Manual*. The Program's policy regarding the frequency of random urine testing is contained in a June 30, 2000 memo from the Diversion Program Administrator, which was then clarified in a March 26, 2001 memo from the Diversion Program Administrator. These memos are contained in an undated

practice medicine, he must secure a "worksite monitor" who must file quarterly written reports on the participant.[404] In addition, if the participant has hospital privileges, the participant must also secure a "hospital monitor" and notify the well-being committee at each hospital at which the participant has privileges. The hospital monitor must also file quarterly written reports on the participant with the Program.[405] If the Program requires a participant to undergo psychotherapy, the treating therapist is also required to file quarterly written reports on the participant's progress.[406] The CM is responsible for ensuring that all of these quarterly reports are received, recorded, and forwarded to headquarters for placement in the participant's file.[407]

Assuming no relapses or other noncompliance, the Program's monitoring continues for at least five years. Participants are expected to file a semi-annual report assessing their own progress toward recovery;[408] these reports are reviewed by the DEC on an annual basis, along with all of the other documentation that is required to be gathered by the case manager, including quarterly worksite and hospital monitor reports, treating therapist reports, and the participant's drug testing history.[409] After two years of continuous sobriety, urine testing may be decreased to three times per month; after three years, it may be decreased to twice per month. Similarly, required group meeting attendance may be reduced to once per week.[410] After three years of sobriety, compliance with the terms of the contract, and adoption of a "lifestyle to maintain a state of sobriety," a participant may be "successfully terminated " from the Diversion Program.[411] At that point, a physician who entered the Program under an SOU is immune from discipline for the alleged violation that resulted in his

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supplemental compilation of Diversion Program policies prepared for the Monitor entitled *Diversion Program Policy, Guidelines, and Procedures*. The rule concerning frequency of required group meeting attendance appears nowhere — not in any statute, regulation, or procedure manual. The closest the Program comes to defining its expectations regarding required group meeting attendance is Appendix D to its *Diversion Program Manual*, which contains a compilation of materials given to new participants. Appendix D states: "During the first eighteen months of participation in the Diversion Program, most participants are expected to attend two Diversion Group meetings a week. At the end of this period, the participant may request a reduction in meeting attendance from two to one a week. Your request should also be discussed with your facilitator and case manager."

[404] Medical Board of California, *Diversion Program Manual*, Ch. 1 at 7.

[405] *Id*. at 7–8.

[406] *Id*. at 8.

[407] *Id*., Ch. 2 at 8.

[408] *Id*. at Appendix D ("semi-annual reports").

[409] *Id*., Ch. 4 at 1, 3.

[410] *See supra* note 403.

[411] Bus. & Prof. Code § 2350(g)(1).

referral to Diversion.[412] Most Diversion Program records of "successfully terminated" participants — including treatment records — are destroyed.[413] Thereafter, the Program does not inquire into or track the sobriety or performance of its graduates in any way.

Due to relapses, however, it takes most participants five to seven years to "successfully terminate" from the Program. Addiction to alcohol or drugs is a chronic, lifelong disease in which relapse and recidivism are expected.[414] Under Diversion Program policy, the consequences for a relapse depend on the facts of the situation, the level of breach, and the way in which it is detected. A January 2000 policy entitled "Response to Relapse" in the *Diversion Program Policy, Guidelines, and Procedures* manual states: "Three factors are considered in evaluating the severity of use and level of impairment. They are: 1) frequency of use (single, multiple, continuous), 2) duration of use, and 3) level of risk (self-report, on/off duty)." The manual also refers to a "Relapse Response Matrix" contained in the same manual, which may be used as "guidelines for Diversion Program staff to assess the appropriate level of treatment for Program participants who have relapsed or are entering the Program."[415] If the physician is practicing medicine at the time of the relapse, he is usually directed to cease practice until he can meet with the DEC, and is placed on the DEC's calendar for the next available meeting. Depending on the circumstances, the Program may also direct the physician to enter treatment, increase the frequency of required urine testing or group meeting attendance, or undergo psychiatric evaluation and/or psychotherapy. According to the Diversion Program Manual, "a participant in the Diversion Program will be considered for termination when the participant has more than three relapses while in the Diversion Program."[416]

In an average of 13 cases per year for the past five years, the Program has "unsuccessfully terminated" a participant. A participant who repeatedly fails to comply with his Diversion Agreement is referred to a DEC at its next available meeting. The DEC makes a recommendation

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[412] *Id*. at § 2350(g).

[413] *Id*. at § 2355(a). A DMQ regulation specifies a few types of Diversion Program records that must be retained in confidence by the Diversion Program. 16 CAL. CODE REGS. § 1357.9.

[414] G. Douglas Talbott, MD and Carolyn Anne Martin, Ph.D., Talbott Recovery Campus, *Relapse and Recovery* (Atlanta, GA 1999) (on file at CPIL); *see also* American Society of Addiction Medicine and National Council on Alcoholism and Drug Dependence, *The Definition of Alcoholism* (policy statement approved by NCADD on Feb. 3, 1990; approved by ASAM's Board of Directors on Feb. 25, 1990) (on file at CPIL).

[415] Neither the "Response to Relapse" document nor the "Relapse Response Matrix" has ever been considered, discussed, or approved by the Board's Diversion Committee, any of its predecessor task forces, or the Division of Medical Quality.

[416] Medical Board of California, *Diversion Program Manual*, Ch. 1 at 4; see also Medical Board of California, *Diversion Program Policy, Guidelines, and Procedures* ("Guidelines for Maximum Relapses While in the Diversion Program") ("a participant in the Diversion Program will be considered for termination when the participant has more than three relapses while in the Diversion Program").

to the Program Administrator, who makes a final decision on whether the participant should be terminated. The consequences of "unsuccessful termination" depend on the type of participant who has unsuccessfully terminated. Participants who are in the Diversion Program under an SOU or as a condition of Board-ordered probation are referred to enforcement, which can then file an accusation for the alleged violation that resulted in the referral to Diversion,[417] or a petition to revoke probation based on the unsuccessful termination. "Self-referred" participants who are "unsuccessfully terminated" will not be referred to enforcement unless the DEC "determines that he or she presents a threat to the public health or safety."[418] According to the Program Manager, DECs do not generally make such a finding unless the participant is actively using drugs or alcohol. Even if the participant is referred to enforcement, only the fact of "unsuccessful termination" is communicated; enforcement does not receive an explanation of the reasons for "unsuccessful termination." Thereafter, the Program does not inquire into or track the sobriety or performance of participants it has unsuccessfully terminated in any way.

F. History of the Diversion Program

As noted above, the Diversion Program's enabling statute was enacted in 1980; the Program was formally created in 1981. The statute expressly requires the Board's Division of Medical Quality to administer the Diversion Program.[419] Specifically, DMQ is charged with the following duties: (1) ensuring that protection of the public is the Program's highest priority ("where rehabilitation and protection are inconsistent, protection shall be paramount");[420] (2) establishing regional DECs and appointing their members;[421] (3) establishing criteria for "the acceptance, denial, or termination of physicians" from the Diversion Program;[422] (4) establishing criteria for the selection of "administrative physicians" who examine physicians requesting admission into the Diversion Program;[423] (5) requiring each DEC to submit a biannual report including information concerning the number of cases accepted, denied, or terminated with compliance or noncompliance,

[417] Bus. & Prof. Code § 2350(e).

[418] *Id*. at § 2350(j)(3).

[419] *Id*. at § 2346.

[420] *Id*. at § 2229(c).

[421] *Id*. at § 2342.

[422] *Id*. at § 2350(a). In 1981, DMQ adopted regulations establishing these criteria; see 16 CAL. CODE REGS. §§ 1357.1, 1357.4, 1357.5.

[423] Bus. & Prof. Code § 2350(h).

and a cost analysis of the program";[424] and (6) "administering the provisions" of the statutes creating the Diversion Program.[425]

Despite this clear delegation of oversight responsibility to DMQ, in 1982, DMQ and the California Medical Association decided to form an external "Liaison Committee to the Diversion Program" (LCD), consisting of representatives of CMA and the California Society of Addition Medicine (CSAM),[426] the chairperson of each DEC, and staff of MBC, the Diversion Program, and CMA. Most of the LCD members are physicians and other licensed professionals whose careers are dedicated to substance abuse detection, treatment, and rehabilitation. The LCD was intended to be an advisory body that brings clinical expertise and external information to DMQ and the Medical Board staff who administer the Diversion Program. According to the minutes of the LCD's first meeting on April 12, 1982, "the Liaison Committee would serve as a place where information and suggestions can be analyzed, providing for different points of view to be represented in the discussion. The Liaison Committee could then bring recommendations to the attention of the Division of Medical Quality where the responsibility and authority for the program operation and policies rests." Notwithstanding the language of the statute and the stated function of the LCD, for all intents and purposes, DMQ effectively delegated its policymaking and oversight role to the LCD in 1982.

In 1982, the Auditor General released the first in a series of audits on the Diversion Program.[427] As described in Chapter IV above, the Auditor General criticized DMQ for failing to establish any formal policies governing surveillance of participant compliance with the terms and conditions of their contracts. Specifically, the Auditor General found wide variability in the case managers' frequency of contact with participants, inadequate monitoring of participant compliance with specific terms of their contracts, inadequate verification of participant attendance at required support group meetings, failure to ensure that treating psychotherapist reports are submitted to the Program, and failure to ensure that participants obtained "worksite monitors" to oversee their medical practice. Additionally, the Auditor General criticized the Diversion Program for inadequate recordkeeping (noting that "records on each participant are scattered among three separate files" across the state) and for failure to terminate participants who do not comply with the terms of their contract. This latter deficiency was attributed to DMQ's failure to establish clear standards and

[424] *Id*. at § 2350(I).

[425] *Id*. at § 2346.

[426] Since then, the composition of the LCD has been expanded to include a representative of the California Psychiatric Association (CPA) and CPA staff.

[427] Auditor General of California, *Review of the Board of Medical Quality Assurance* (No. P-035) (August 1982) (hereinafter "1982 Auditor General Report").

guidelines for terminating participants. In response, DMQ promised to hire a deputy program manager to better supervise the case managers, draft formal guidelines for practice monitoring (to include a requirement that the participant submit a plan of employment to the case manager, who would then inspect the work environment, interview the prospective supervisor, and ensure the supervisor understands his or her responsibilities), and formulate standards for terminating participants from the Program.

In January 1985, the Auditor General released a follow-up report.[428] The Auditor General found continuing problems with the case managers. Although Program policy required CMs to visit participants on a monthly basis, the Auditor General determined that the CMs were not meeting this requirement and some were substituting telephone contacts for personal visits. One of the CMs had not personally visited any of the participants in his portfolio for the prior year. At that time, CMs were responsible for collecting urine specimens at least once per month; the Auditor General found deficiencies in this function as well. In one case, the CM either did not collect required urine samples or collected and discarded them without testing. As it had in 1982, the Auditor General found deficiencies in the Program's worksite monitoring system, including the Program's failure to provide worksite monitors with copies of the participant's treatment plan, participants' failure to obtain a monitor within required timeframes (or obtaining a monitor who was also a participant in the Diversion Program), failure by monitors to fulfill their monitoring responsibilities, and failure by monitors to file quarterly written reports. Once again, the Auditor General found that the Program failed to provide worksite monitors with a detailed description of their duties, including the level, degree, and frequency of supervision and observation expected by the Program. The Auditor General found that the Program Administrator had failed to suspend several participants who should have been suspended, and failed to refer several participants to the DEC for termination from the Program where they had repeatedly failed to comply with the terms and conditions of their treatment plan.[429] Concerning the management of the Program, the Auditor General stated that "the medical board's staff has not developed adequate procedures for supervising the diversion program and for ensuring that the diversion program is protecting the public." Specifically, the monthly reports filed by CMs and the Program Administrator contained insufficient information to enable the Chief Medical Consultant (who was supposed to be responsible for supervising the Diversion Program) to assess the performance of the CMs, Program Administrator, or the Program generally. The Auditor General noted that there was no tracking of the frequency of CM visits to participants or

[428] Auditor General of California, *The State's Diversion Programs Do Not Adequately Protect the Public from Health Professionals Who Suffer from Alcoholism or Drug Abuse* (No. P-425) (January 1985) (hereinafter "1985 Auditor General Report").

[429] The Auditor General described an astounding example of this critical failure: "On four separate occasions over a three-month period, urine samples collected from the participant during his office hours revealed that he was under the influence of alcohol." Yet the Program Manager failed to require the physician to cease practicing, and he failed to terminate him from the Program. *Id*. at 23.

urine sample collections, and no comparison of compliance reports with the participant's treatment plan.

The Auditor General concluded that these persistent and systemic problem exist because the Medical Board "has not adequately supervised the diversion program." The Auditor General recommended that the Diversion Program provide CMs with training in their duties, improve its system for tracking the CMs' activities in monitoring participants, and develop new guidelines for worksite monitors "that describe the observations they must make of participants, how frequently they must observe the participants, how often they must collect urine samples, and what information they should include in their quarterly reports." The Auditor General stated that the Medical Board must "specify . . . the kinds of noncompliance that warrant suspension or termination, develop a system to ensure that the program manager consults with [DECs] when participants violate significant terms and conditions of their treatment plans, . . . [and] develop a reporting system for the diversion program that will provide the medical board with enough information to supervise the program properly." Once again, MBC promised to address the issues identified by the Auditor General.

In 1986, the Auditor General released another report,[430] again finding deficiencies with the CMs' personal visits to participants. Of the 21 participants examined, 17 (81%) were not visited for periods ranging from three to seven months. Over 70% of participants that were required to undergo monthly urine screening did not have samples collected as frequently as required. The Auditor General found continuing problems with worksite monitors as well — 86% of worksite monitors were not contacted by CMs as frequently as required, and 71% of worksite monitors had not signed and returned their letter of acknowledgment. The Auditor General criticized the CMs' recordkeeping and the Program Administrator's failure to check the adequacy and accuracy of records submitted by the CMs. The Board agreed to implement a computerized participant profile and tracking system to enable the Program to identify participants who were not being adequately monitored by the CMs, and to continue its training of CMs on its expectations regarding their monitoring of Diversion Program participants.

In 1993, the California Highway Patrol released its report on MBC's enforcement program.[431] As part of its investigation, the CHP examined several allegations of misconduct and corruption within the Diversion Program. Although the CHP made no definitive findings, it expressed concern that group facilitators characterized as "volunteers" were in fact making up to $7,000 per month for

[430] Auditor General of California, *The Board of Medical Quality Assurance Has Made Progress in Improving its Diversion Program; Some Problems Remain* (No. P-576) (June 1986) (hereinafter "1986 Auditor General Report").

[431] California Highway Patrol, Bureau of Internal Affairs, *Administrative Proceedings of the Medical Board of California (Preliminary Report)* (Jan. 11, 1993).

holding two meetings per week; one case manager was not collecting urine samples from participants as frequently as required; some Diversion staff made "threatening" comments to participants; and the Program Manager improperly accepted expensive gifts from participants in the Program. Following the Medical Summit in March 1993, MBC appointed a task force to examine the CHP's concerns. After meeting for about six months, the task force disbanded without recommending any substantive changes to any aspect of the Diversion Program.[432]

In March 1995, the State Auditor (formerly the Auditor General) released its audit of MBC's enforcement program as required by SB 916 (Presley). The Auditor noted that effective January 1, 1993, AB 2743 (Frazee) (Chapter 1289, Statutes of 1992) added section 125.3 to the Business and Professions Code, enabling MBC to create a cost recovery mechanism (such as that recommended in *Code Blue* six years earlier) to recoup some of its investigative and enforcement costs from disciplined licensees. The Auditor found that MBC spent over $25 million on enforcement during 1993–94, could have recovered $6.3 million in cost recovery, but recovered only $94,000 because of its failure to properly implement its cost recovery authority. The Auditor pointed specifically to MBC's failure to seek recovery of its costs to administer the Diversion Program as against physicians who are ordered to participate in it as an alternative to disciplinary action or pursuant to a stipulated settlement. According to the Auditor, "as of June 25, 1992, 118 (46 percent) of the 256 participants were ordered to participate in the diversion program as an alternative to other disciplinary actions. Similarly as of July 31, 1993, 82 (38 percent) of the 213 active participants in the diversion program were ordered to participate. The law does not prohibit the medical board from seeking recovery of the proportion of the diversion program's administrative costs relating to those individuals ordered to participate in the program as an alternative to facing other disciplinary action. Using the numbers of participants ordered into the program for the two years we reviewed, we determined that the medical board could have sought recovery of approximately $332,500 for fiscal year 1992–93 and $284,600 for fiscal year 1993–94."[433]

In 1996, the Legislature enacted AB 1974 (Friedman) (Chapter 644, Statutes of 1996) to give the Diversion Program a new responsibility unrelated to substance abuse. Under Business and Professions Code section 821.5, hospital peer review bodies that are investigating a physician's ability to practice medicine "based on information that the physician and surgeon may be suffering from a disabling mental or physical condition that poses a threat to patient care" must file a confidential report with the Diversion Program Administrator. The Administrator must contact the peer review body within 60 days and "periodically thereafter to monitor the progress of the investigation. At any time, if the diversion program administrator determines that the progress of

[432] *See supra* Ch. IV.D.

[433] State Auditor of California, *The Medical Board Needs to Maximize Its Recovery of Costs* (No. 93032) (March 1995) at 14–15.

the investigation is not adequate to protect the public, the diversion program administrator shall notify the chief of enforcement of the Division of Medical Quality of the Medical Board of California, who shall promptly conduct an investigation of the matter."[434]

During this time period, the Diversion Program Administrator would make brief reports at each quarterly DMQ meeting. Division members knew little about the functioning of the Program other than what it was told by staff, which would present a five-minute oral report and a one-page written report containing minimal statistics dating back to the inception of the Program in 1981 — including total number of intakes, participants, releases, and some information about the "primary drugs of choice" among Diversion Program participants. No DMQ members fully understood how the Program worked; their questions to staff generally went unanswered. With the exception of the CHP report in 1993 and a 1994 effort to craft legislation to supersede a troublesome court decision applicable to the authority of MBC to discipline a physician in the Diversion Program,[435] it is fair to say that DMQ paid little serious attention to the Diversion Program until 1997.

In 1997, the Center for Public Interest Law raised questions about the Diversion Program in testimony to the Joint Legislative Sunset Review Committee at the Board's first sunset review. CPIL expressed concern about DMQ's failure to properly oversee the Diversion Program; specifically, CPIL alleged that DMQ had delegated its oversight role to the LCD, and had failed to discuss or adopt standards for urine test frequency and the handling of relapses, criteria governing a physician's readiness to return to practice and justifying termination from the Program, and qualifications for the "evaluating physicians" who examine applicants to the Diversion Program. CPIL noted that the DECs were making decisions (not recommendations) about whether and under what terms and conditions a participant may practice medicine — decisions that were not reviewed or ratified by any Medical Board staff or Board member, and decisions that are properly made by government officials and not private parties. CPIL questioned the effectiveness of the Diversion Program — noting that the Program had "graduated" only 590 physicians and unsuccessfully terminated 267 physicians since its inception in 1981. CPIL also expressed concern over the infrequency of required urine testing (twice per month); the Program's inability to monitor participants who had agreed to cease practice; its lack of standards, policy, or expectations when handling relapses; its failure to demand practice cessation during the initial comprehensive evaluation; and its constant advertisement of a

[434] MBC has adopted regulations to implement section 821.5; *see* 16 CAL. CODE REGS. § 1362 *et seq*. In 2004, the Diversion Program Administrator estimated that she receives approximately one section 821.5 report per month.

[435] In *Kees v. Medical Board of California* (1992) 7 Cal. App. 4th 1801, the Fourth District Court of Appeal stated that "once a physician enters the . . . [diversion] program . . . , the Board halts all action against the physician, whether it is investigatory or disciplinary." This language led the enforcement program to insist on completing all investigations on physicians seeking admission into the Diversion Program before formally admitting a physician with a complaint pending into the Program. MBC and CMA negotiations led to the enactment of SB 779 (Lewis) (Chapter 252, Statutes of 1995) to repeal the language in *Kees* and clarify the procedures to be followed when a physician against whom a complaint is pending seeks admission into the Diversion Program.

"69% success rate" when it wholly failed to track the post-termination activities of any of its participants. CPIL recommended that the Legislature require DMQ to engage in substantive rulemaking and oversight of the Diversion Program ("DMQ should be required to adopt protocols, procedures, and reporting requirements about the decisionmaking of the Diversion Program which staff must follow, and to develop intrusive monitoring mechanisms to enable the Division to ensure that staff is in fact following them"), amend the statutes creating the DECs to ensure they act in an advisory capacity only, require Diversion Program participants to cease practice during the initial evaluative stage of participation, and ask the State Auditor to undertake another independent look at the Diversion Program to ensure that the problems first identified in 1982 had been corrected.

In response to CPIL's testimony, MBC created a Task Force in 1998 to comprehensively study the Program; examine the precise functioning of the Program; and determine who was making decisions, whether they are qualified to make those decisions, and whether they should be allowed to make those decisions. In May 2000, the Task Force reviewed the issue of urine test frequency and decided to increase the frequency of urine testing for participants permitted to practice medicine — one of the few Diversion-related policy decisions made by MBC members.[436] The work of the Task Force also led to 2000 legislation clarifying that the Program Administrator makes Diversion Program decisions and the DECs serve in an advisory capacity to the Administrator, extending the minimum period of sobriety from two years to three years (for purposes of successful completion of the program), and making a number of other important changes to the Diversion Program's statutes.[437]

In July 2000, the Task Force began to require Diversion Program staff to compile and present "Quarterly Quality Review" (QQR) reports containing data on three important performance measures: (1) total intakes during the quarter — that is, the number of physicians who contacted the Program; the time it took the Program to respond with a face-to-face meeting with the CM, group meeting attendance, a complete mental and physical evaluation by a competent evaluating physician, a DEC meeting, and formal admission into the Program; and the status of all physicians who contacted the Program during that quarter; (2) total relapses during the quarter — including the method and details of the Program's detection of reuse, the timeliness and substance of the Program's response to the relapse, how long the participant had been in the Program at the time of relapse, whether the participant was a self-referral or Board referral, and the participant's current status; and (3) total releases during the quarter — both "successful completions" and "unsuccessful completions" with factual details on each. The information presented in these reports is anonymous, and tended to be about six months old by the time the Task Force reviewed it, but it was the Board's first meaningful attempt to supervise and oversee the Program's functioning as required by law.

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[436] This policy decision was reflected not in statute or regulation, but in a June 30, 2000 memo from the Diversion Program Administrator to the Diversion Task Force.

[437] SB 1554 (Figueroa), Cal.Stats.2000, c. 836.

In November 2000, the Board converted the Task Force to a standing Committee on the Diversion Program, to ensure that some members of the Board are familiar with the Diversion Program, its statutes and regulations, and its policies and procedures. The Committee meets quarterly in public, reviews the QQR reports, receives a report from the LCD, and occasionally studies and/or decides a policy issue related to the Diversion Program.

In 2002, SB 1950 (Figueroa) amended section 2350 to permit the "diversion" of singly-diagnosed mentally ill physicians from enforcement into the Diversion Program. The Program was then confronted with integrating singly-diagnosed mentally ill physicians into a program that — for twenty years — had been primarily structured to monitor chemically dependent physicians. A 2001 memo from Medical Board staff anticipated no serious problems in accommodating mentally ill physicians; the memo stated that they could be reviewed by existing DECs or that the Program could create a special DEC specifically for mentally ill physicians. Staff noted that the Program would probably need one additional case manager — "not including support staff or administrative services, the fiscal impact would be near $80,000 per year (some of which would be offset by the savings to Enforcement)." Based on this estimate, CMA and MBC agreed to the inclusion of the provision in SB 1950 (Figueroa). In February 2003, however, the Diversion Program Administrator wrote a memo anticipating a 30% increase in Program participation over the following five years due to the inclusion of mentally ill physicians. Of greater import, the memo described the burdens imposed by the addition of mentally ill physicians to the Diversion Program: "Physicians with mental illness are expected to have reoccurring symptoms of their disease that will require intervention and treatment at a much greater frequency than those with chemical dependency that relapse into substance abuse. As such, the singly diagnosed mentally ill are expected to significantly compound the workload of the program's case managers by increasing the time involved with monitoring and providing referrals for these physicians." The Administrator opined that if the anticipated number of singly-diagnosed mentally ill physicians enters the Diversion Program over the next five years, it will need eight new case managers at a cost of an additional $600,000 per year (a 60% increase in the Diversion Program's budget).

Even without the addition of mentally ill physicians, the Program's staffing has been stretched to its breaking point. At the end of fiscal year 1994–95, a total of 212 physicians were participating in the Diversion Program,[438] which was staffed by ten people (including five CMs). During 1994–95, the average caseload of the case managers was 49 cases[439] — which is the maximum believed prudent by the Program Administrator. At the end of fiscal year 2003–04, a total

[438] Medical Board of California, *1994–95 Annual Report* (October 1995) at vii.

[439] Diversion Program, Medical Board of California, *Second Annual Report* (1995) at 8.

of 258 physicians were participating in the Program,[440] which was still staffed by ten people (including five CMs). During early 2002, the caseloads of at least three CMs soared to above 80 cases each, causing the Program to impose "dampening activities" to stifle the number of participants in these "impacted" regions of the state. The Program "delayed entry" to applicants in these areas of the state until the CMs' caseloads decreased to a somewhat more manageable level,[441] and also relieved those CMs of some of the monitoring activities which they would otherwise be required to perform.[442] In other words, between 1994–95 and 2003–04, the Program's participation rate increased by 22% with no increase in staffing, and — in some areas of the state — participants are not monitored as comprehensively as called for by Program policy.

Additionally, on at least two occasions during the past three years, the Program Administrator has had to abandon her position in Sacramento in order to temporarily fill in for a case manager in the field who resigned. On these occasions, the Program Administrator has become a case manager for several months (until the hiring freeze waiver could be secured and the position could be filled), requiring the Deputy Executive Director to assume the duties of Acting Diversion Program Administrator. It is unclear what happens when these critical case managers — who are the "nerve center" for information exchange regarding potentially dangerous physicians — go on vacation for even a day.

G. Initial Concerns of the MBC Enforcement Monitor

The Monitor's review of the Diversion Program's statute and regulations, its policy and procedure manuals, its computer tracking system, its participant files, and its oversight have revealed fundamental flaws in its operation that are described below. However, the following critique does not imply that the Diversion Program has never helped a physician recover from addiction. Our review of the files on twenty "imminent completion" participants tells us that it has. Similarly, the

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[440] Medical Board of California, *2003–04 Annual Report* (October 2003) at v.

[441] According to the Program Administrator, the "goal" maximum caseload for case managers is 50 cases. When a CM reaches 65 cases, the Administrator declares the area of the state served by that case manager to be "impacted" and "delays entry" to prospective participants in that area until the case manager's caseload drops below 65. As of July 26, 2004, one CM had 70 cases (so was "impacted") and another's caseload had dropped to 62 cases so that CM could accept new participants. Interview with Diversion Program Administrator (July 26, 2004).

[442] In memos dated March 11, 2002 and March 29, 2002, Diversion Program management lengthened the time within which intake interviews must be conducted by case managers from the usual one week from the date the physician contacts the Program to an unspecified time "within the discretion of the case manager." The Program also suspended the usually-required use of the "Intake Interview Guide Sheet" and left it up to the discretion of the case manager as to what information should be collected in the intake interview. Finally, the Program changed the monthly group meeting attendance requirement for case managers to "the Case Manager is to use discretion in determining the frequency of attendance at Diversion Group meetings." In 2004 interviews with the Diversion Program Administrator, she stated that those memos are directed only at case managers with caseloads in excess of 65 cases (two of the five CMs had caseloads in excess of 75 cases); other CMs should abide by the usual rules.

Monitor has nothing but respect for the people who are employed by and who volunteer their time, skills, and expertise to the Diversion Program. However, this Program operates in an area of extraordinary sensitivity and patient risk. If the Program or its monitoring mechanisms fail for whatever reason, both the public and its participants are subject to grave harm.

1. The Diversion Program is significantly flawed by the simultaneous confluence of (a) the failure of its most important monitoring mechanisms and an insufficient number of internal quality controls to ensure that those failures are detectable by Program staff so they can be corrected, and (b) such pervasive and long-standing understaffing that Program staff could not correct those failures even if they knew about them.

a. All of the Program's most important monitoring mechanisms are failing, and there are an insufficient number of internal quality controls to detect those failures. The primary purpose — and promise — of the Diversion Program is adequate monitoring of impaired physicians while they are impaired, recovering, and retain their full and unrestricted license to practice medicine. The Program purports to monitor impaired physicians through a variety of mechanisms, the most important of which are random urine screening requirements, case manager attendance at required group meetings, required worksite monitoring, and regular reporting by treating psychotherapists. Most of these monitoring mechanisms are failing the Program and the public, and — as described below — the Program lacks internal quality controls that would otherwise enable staff to detect these failures. As a result, Program staff and oversight authorities are unaware of the deficiencies that exist in the Program and falsely assume that the Program is effectively monitoring participants when it is not. A comprehensive overhaul of the Diversion Program is urgently needed to correct longstanding deficiencies that limit the Program's effectiveness both in terms of assisting participant recovery and in terms of protecting the public.

(1) The Program's urine collection system is fundamentally flawed. The Diversion Program uses random urine collections as a primary means for monitoring participants' sobriety and detecting relapses. Available data suggest that more than 70% of relapses are detected directly, or indirectly, from these tests. Thus, the Diversion Program's urine collection system is the major objective measure of participant compliance with the terms of the contract and with the Program's requirements. However, the results of our review suggest that the confluence of various deficiencies in the current system delays the Program's detection of participant relapses (in some cases for an extended period of time) or prevents that detection entirely. In our view, these deficiencies seriously undermine the integrity of the major objective measurement of participant compliance, and may expose the public to unacceptable risk.

As described above, at least three levels of Diversion Program staff are supposed to play a "gatekeeper" role in implementing and monitoring the urine collection system: (1) the Collection

System Manager (CSM), a Sacramento-based staff employee who provides oversight and coordination of the urine collection system; (2) regional case managers (CMs) who monitor a caseload of participants in their region; and (3) local urine collectors who are supposed to collect specimens from participants according to a random schedule of monthly dates generated by the CSM. Each of these "gatekeepers" is in a position to monitor participant compliance with the Program's urine collection requirements; however, excessive caseloads and a lack of internal controls on the system have combined to prevent any of these people from detecting the problems that we have documented.

Diversion Program policy requires participants who are practicing medicine to be tested four times per month for the first two years of participation. These collections are supposed to be randomly scheduled by the CSM and observed by the local urine collector. After 24 months of participation (which must include a similar period of sobriety), scheduled collections may be reduced to three collections per month. After 36 months of participation (which must include a similar period of sobriety), scheduled collections may be further reduced to two collections per month. Non-practicing participants are usually scheduled for two collections per month irrespective of how long they have been in the Diversion Program.

On a monthly basis, the CSM generates a master list of randomly-generated urine collection dates for various groups of participants in different geographical regions of the state. Individualized listings are then prepared for each case manager, group facilitator, and collector.

In preparing the list of random dates, the CSM is highly dependent on the CMs to provide updated information regarding the Program's participants. If the case managers do not notify the CSM of changes to the list of participants for whom collections are needed, changes in the number of needed collections per month, or changes in participants' practice status or unavailability for testing due to treatment or other circumstance, then the monthly master schedules prepared by the CSM will necessarily be out of alignment with actual collection requirements. Further, the system used to prepare the monthly collection schedules does not permit the CSM to block out dates for individual participants in order to avoid scheduling collections on dates when it is known that they will be unavailable due to vacations or other approved absences. The case managers and collectors are responsible for making any changes to the schedules prepared by the CSM as needed to accommodate requests that have been submitted by participants for vacations or other approved absences. The CSM does not oversee, control, or monitor changes made to the collection schedules after they are generated and distributed.

On the date randomly generated by the computer — and that date can be a weekday, a weekend day (Friday, Saturday, or Sunday), Christmas Day, Easter Sunday, or Super Bowl Sunday (whatever date the computer generates), the collector is supposed to call the participant and instruct

the participant where and by when he must present himself for a collection. According to the *Diversion Program Manual*, the physician is required to provide a sample within six hours of the call. The participant shows up and submits to an observed urine collection, and pays the collector both the collection fee and the lab fee. The collector prepares paperwork for the laboratory that will analyze the specimen. The paperwork prepared by the collector does not indicate the participant's name; instead, all participants are given a "Donor ID" number, and that number is entered onto the chain of custody form prepared by the collector.

The collector then overnight-mails the specimen to the laboratory used by the Program. The Program's arrangement with the lab gives it an outside window of 12 hours to return a result if the result is negative. The lab is allowed up to 72 hours to return a positive result. Sometimes (most of the time) a positive result will come earlier than that outside window; sometimes it does not.

The results of all urine tests come to the Diversion Program in two ways:

(1) All positive results are communicated to the CSM. The CSM identifies the participant who tested positive from the Donor ID, and emails the case manager of that participant so that the CM can begin a fairly complex chain of events to determine whether the positive result is in fact evidence of a relapse. Not all positive tests indicate relapse; some participants are taking prescription drugs that have been approved by the Program, and those drugs show up in the test. Other physicians test positive because they say they have eaten poppy seeds, or taken cough medicine with codeine, or used mouthwash containing alcohol.

(2) All results of all urine tests — both positive and negative — are electronically forwarded to the Program by the lab via a "data dump." These test results are then "appended" to the electronic file of the tested participant in the Program's Diversion Tracking System. Theoretically, the DTS contains detailed information regarding the date and result of each urine test completed.

The CSM and case managers review and respond only to reports of positive tests. Reports of negative tests are reviewed only superficially, or not at all. If positive test reports are not received, all Program staff assume that the collections were completed as scheduled and that the test results were negative. They also assume that the results of all completed tests are correctly downloaded and appended to each participant's record in the DTS. However, these assumptions are frequently erroneous, and there are very few control mechanisms to detect those errors. Specifically, there are not sufficient positive controls on the current collection system to provide assurance of six major components:

- All active participants are included in the master collection schedule.
- The participant is scheduled for the required number of tests, per the Diversion Program "frequency of testing" policy described above.

- Collections are actually completed on the random date assigned by the CSM.
- The same number of collections is completed as is scheduled for each participant.
- Collected specimens are received at and processed by the laboratory.
- Test results are correctly downloaded and appended to each participant's record in the DTS.

Due to the absence of sufficient positive controls over the scheduling and collection process, participants can be tested less frequently than required, or not tested at all, for an extended period of time without anybody ever detecting that there is a problem. Also, test results may be inadvertently appended to the wrong participant's record in the DTS, or not appended to any record in the DTS, without anybody ever detecting that there is a problem. All of these events have occurred. We found significant defects in four areas of the Diversion Program's urine collection system: (A) collection scheduling process deficiencies; (B) specimen collection process deficiencies; (C) reporting and recordkeeping deficiencies; and (D) urine collection system oversight deficiencies.

A. Collection Scheduling Process Deficiencies

1. New participants are not always promptly scheduled for urine collections. Diversion Program policy requires new participants to be scheduled for collections immediately following completion of their intake interview. If the participant will be immediately entering or is already in treatment, the collections are usually supposed to begin immediately following completion of treatment. In most cases, the case manager initially needs to schedule the collections directly with a collector for a period of several weeks until the participant can be incorporated into the CSM's master scheduling system.

Although the Program assures the public of "immediate drug testing," our review of 20 recently completed intakes identified one participant who was not scheduled for any collections (or tested) for the first three months following completion of his intake interview. Four other participants were not scheduled for any collections (or tested) for at least the first month following completion of their intake interview. These data suggest that about 25% of new participants are not promptly scheduled for any collections (or tested) for a period of at least a month following completion of their intake interview — and most of these participants are permitted to practice medicine. During the transitional period following initial intake and, if applicable, completion of inpatient treatment, it is particularly important to assure that urine testing is completed on a regular basis.

2. Urine collections are not always promptly restarted when a participant completes treatment following a relapse. Participants are usually required to obtain treatment after a relapse.

Generally, inpatient treatment is recommended and, during the treatment period, Diversion Program urine collections are suspended. Urine collections are supposed to be restarted immediately following a participant's release from treatment. In most cases, the case manager needs to initially schedule the collections directly with a collector for a period of several weeks until the participant can be incorporated into the CSM's master scheduling system.

However, our review of 20 recent relapse cases identified four cases where urine collections were not promptly restarted following completion of treatment. Following release from treatment, these four participants were not tested for periods of time ranging from 3 to 4½ months. Although participants are not usually permitted to immediately return to practice following release from treatment, this is not always the case. During the transitional period following release from treatment, it is particularly important to assure that urine testing is completed on a regular basis.

3. The CSM is not always promptly notified by the case managers of the need to add new participants to the random urine collection scheduling system. New participants should be included in the CSM's random urine collection scheduling system within one month of completion of their intake interview. If the individual is already in an inpatient treatment program at the time the intake interview is completed, or will be entering treatment in the near future, then his inclusion in the CSM's collection scheduling system is deferred until treatment is completed.

However, our review of 20 recently completed intake cases identified nine cases — almost 50% of the cases we reviewed — where the participants were not randomly scheduled for collections through the CSM for periods ranging from one month to as many as four months following completion of their intake interview or, if applicable, release from treatment. In some cases, rather than scheduling collections through the CSM, the case managers continued to schedule the participant's collections directly with the collectors on an ad hoc basis.

4. The CSM is not always promptly notified of changes to participants' testing frequency. Participants oftentimes are scheduled by the CSM for four collections per month when a lesser number of collections is required due to the participant's practice status or length of time in the Diversion Program without a relapse. In these circumstances, the case manager and/or collector unilaterally determine which dates to delete from the list of random collection dates generated by the CSM. In some cases, this practice continues for a period of several months before the CSM is alerted to the need to adjust the participant's collection schedule. The practice of repeatedly overriding the random collection schedule generated by the CSM, rather than notifying the CSM of needed changes to a participant's collection requirements, undermines the integrity of the random collection scheduling system.

B. Specimen Collection Process Deficiencies

1. Collectors do not usually obtain urine specimens on the dates specified in the CSM's master collection schedule. We compared scheduled collections with actual collections for periods ranging from four to eleven months for each of 20 recently completed intake cases. A total of 378 collections were scheduled. Collections were actually completed on the date that had been scheduled only 40% of the time. In addition to scheduling changes resulting from needs to accommodate participant unavailability due to vacations, meetings, etc., schedules were sometimes changed for the convenience of or due to the unavailability of the collector.

There are no controls over many of the changes to the random collection schedule that are made and, in most cases, the reasons for the changes are not documented. The systemic rescheduling of collections by case managers and/or collectors raises serious questions about the integrity of the Diversion Program's random collection scheduling system.

2. Collectors disproportionately shift collections from weekends to weekdays. Collectors disproportionately shift collections from weekend days (Friday, Saturday, and Sunday) to weekdays, particularly Tuesday and Thursday. Among the 20 recently completed intake cases that we reviewed, 22% fewer collections were completed on weekends compared to the number that were scheduled for those days. Significantly more collections were completed on both Tuesdays and Thursdays than were scheduled. The reduced frequency of testing on weekends and increased frequency of testing on Tuesdays and Thursdays potentially enables participants to "game" the system by anticipating when they are least likely to be tested.[443]

3. Collectors do not always make up for skipped collections. When a collector decides to skip a collection on a scheduled day due to his own vacation, meeting, scheduling conflict, or other circumstance, a make-up collection is not always scheduled. As a result, many participants complete fewer collections than are scheduled. Additionally, some collections are skipped when the participant is unavailable due to meetings or other circumstances. Skipped collections due to participant unavailability may be symptomatic of a relapse and, because of this, should be of particular concern — especially when they are not made up.

C. Reporting and Recordkeeping Deficiencies

1. Reporting of test results is sometimes delayed. As noted above, the Diversion Program's arrangement with the lab calls for positive results to be reported to the Program within

[443] Participants are able to "game" the system in other ways. For example, most participants are aware of the general requirement of four urine tests per month during the first two years of participation. If a participant is tested four times by the tenth of the month, that participant knows the odds are he will not be tested again until the following month.

72 hours. Our review of 20 recent relapse cases identified four cases where positive test results were not reported for timeframes ranging 10 to 14 days after the sample was obtained. In another case, test results were not reported for as long as 3 to 4 weeks after the sample was obtained. In most cases, reporting delays are attributable to failure by the collector to submit the specimen to the laboratory on a timely basis. The problem is exacerbated by the fact that Diversion Program staff do not identify these problems when they occur, or do not immediately initiate corrective action to prevent the problems from recurring in the future.

2. There are gaps in the collection records maintained in the DTS. The DTS is used to maintain a record of urine test results for all participants from late 2001 to the present. However, the Diversion Program does not have positive controls to assure that test results are actually received from the laboratory and downloaded to the DTS. It also is possible that data can be inadvertently erased or purged from the system without being detected. For example: (1) there are no records in the DTS of any urine tests during June 2002 for any of 60 participants that we checked. Diversion Program staff are unable to explain what may have caused this gap; (2) there are no records in the DTS for any urine tests for most of May 2003. This is the same time that the Program switched to a new laboratory service. It appears that several weeks' worth of records from the former laboratory were never downloaded to the DTS. It is unlikely that these records can be recovered; and (3) a set of records covering testing during a two-week period in late January and early February 2004 also was missing in the DTS. After the Monitor brought this problem to the attention of the Diversion Program Administrator, the missing records were identified, located, and appended to the DTS.

3. Test results are not always appended to the correct participant's DTS file. Our reviews of 60 Diversion Program files identified numerous inconsistencies between the dates of completed tests shown in the database maintained by the laboratory service and the dates shown in the Program's DTS. These problems often occur because the Donor ID number is not entered onto the chain of custody form by the collector, or the Donor ID number entered is incorrect. In cooperation with the Diversion Program Administrator, we determined that more than 300 lab reports received during the past year did not contain a Donor ID and therefore had not been appended to the appropriate participant's record in the DTS. These records have since been corrected and appended to the appropriate files in the DTS. However, there are still a number of records with incorrect (versus missing) Donor IDs that may, or may not, already be appended to the correct participant's record in the DTS. MBC's Information Technology Services Division staff have indicated that there are no records that have been downloaded but not appended, so it is unclear what happened to records that had incorrect Donor IDs when they were downloaded.

One of the cases that we reviewed involved a non-practicing participant who appeared not to have been tested for the past full year after several years of participation in the Program. We subsequently determined that the participant's collector had been using the wrong Donor ID for this

participant's specimens. Consequently, the test results for this participant were posted to another participant's record in the DTS. After reviewing all of the past year's test results for the other participant, the incorrectly posted records were able to be identified. It was then learned that, during six of the past twelve months, this participant was tested only one time per month. None of the Diversion Program's "gatekeepers" detected any of these problems.

Finally, our review of 20 recent relapse cases identified a practicing participant who appeared not to have been tested for an eight-month period extending from mid-April 2003 through January 2004. Program staff are unable to determine whether the participant was actually tested during this period and the results were posted to another participant's file, or whether the participant wasn't tested. During this period the participant relapsed. The relapse was detected not by the Diversion Program but by the participant's employer.

4. Incorrect data have sometimes been reported. Primarily as a result of data entry errors, some of the data reported by the lab to the Diversion Program are incorrect. For example, we completed our reviews during April and May 2004, but saw several laboratory reports with collection or reporting dates during late 2004 or 2005. We also saw examples of obvious inconsistencies between the dates shown for urine collection, lab receipt of the specimen, and reporting of the results (*e.g.*, a subsequent event, such as a report, occurring before the preceding event, such as a collection). The laboratory recently reinstituted double-key data entry procedures that should help to reduce the magnitude of these types of problems in the future.

5. Most local collectors fail to file a required monthly report. The Diversion Program Manual requires local urine collectors to file a monthly report detailing the dates of all urine collections on all participants, including the specimen chain of custody number. This monthly report could help Program staff in detecting errors. The Manual also requires local collectors to "cite reasons for adjusting a collection date." However, the majority of collectors fail to file monthly reports, and Program staff do not insist on compliance with this requirement. We randomly looked at the CSM's binder for the month of December 2003. Out of 30 collectors collecting from 60 different groups of participants, only five (5) collectors (covering 9 groups) submitted the required monthly report for that month. It is unclear whether the Program has a standardized form for this report; we looked but could not find one.

D. Urine Collection System Oversight Deficiencies

1. Program staff do not adequately monitor the collectors. As discussed previously, collectors appear to have broad discretion to unilaterally modify the collection schedules prepared by the CSM or, in some cases, skip collections altogether. As a result, many participants are not tested on the dates scheduled or are not tested as frequently as required. We are aware that the

Program has terminated several collectors for egregious and longstanding lapses. However, routine modification of random schedules without explanation, skipped collections, and collector failure to file a monthly report of all collections appear to be tolerated without discussion or sanction. It is unclear whether Program staff even know these events are occurring.

2. Program staff do not periodically review individual participant collection histories. Diversion Program staff do not routinely, or even periodically, review individual participant urine collection records. If a positive test is reported for a participant, the case manager initiates consultations with all concerned parties in response to that specific report. However, if no positive test results are reported, Diversion Program staff assume that all required collections have been completed as scheduled, submitted to the laboratory for testing, and reported as negative results.

The above assumptions are sometimes false. In most cases, specimens are not collected on the dates scheduled and, in many cases, specimens are not collected as frequently as required. In some cases, specimens are not collected at all for extended periods of time and nobody, other than the participant, is aware that this is occurring.

The results of our review suggest that at least several dozen of the Diversion Program's current participants have, at some point, not been tested for an extended period of time when they should have been. The results of our review also suggest that many more participants are not being consistently tested as often as they should be. Nobody currently makes any effort to track or monitor actual collections on a proactive basis for purposes of (1) controlling unapproved changes to the collection schedule that otherwise might be made for the convenience of the collectors or participants, (2) assuring that the required number of tests is actually completed for each participant, and (3) detecting relapse behaviors in advance or in lieu of actually receiving a positive test result.

3. Diversion Program staff have not usually responded to negative-dilute test results. Sometimes, participants who have resumed use of drugs or alcohol attempt to "dilute" their urine by ingesting large quantities of liquid. A "positive-dilute" result means that the specimen has registered over the threshold for a specific drug and is also diluted. A "negative-dilute" result means that the specimen registered under the threshold and is diluted. During April 2004, the Monitor pointed out to the Diversion Program Administrator several instances where a pattern of negative-dilute specimens was followed by a relapse. The Monitor also pointed out two cases where there was a recent pattern of negative-dilutes which suggested that the participant may have relapsed. Program staff subsequently determined that both of these participants had relapsed.

In many cases, negative-dilute test results clearly reflect a participant's efforts to disguise his relapse. Therefore, negative-dilutes should be recognized and addressed immediately. However, the Program had no policy regarding appropriate reaction to negative-dilute tests prior to April 2004.

In response to the Monitor's concerns, the Diversion Program Administrator recently established a new policy to require that case managers review and initiate appropriate responses in cases where negative-dilute specimens are obtained (for example, by immediately ordering a replacement collection and, in some cases, using alternative testing protocols).

To summarize, the Diversion Program today in 2004 is plagued by the same problem found by the Auditor General in 1985[444]and again in 1986[445]: The Diversion Program cannot guarantee the public that its participants are being tested as frequently as it requires. Focusing specifically on Diversion Program participants who are permitted to practice medicine, about one-half of recent intakes were not tested as often as required during the first one to four months of participation. About 25% of new participants were not tested at all for at least one month following completion of the intake interview. The relapse cases we reviewed indicated that five of the 20 participants who relapsed — all of whom were practicing medicine — were not tested as often as required. The public is exposed to unnecessary risk.

And consumers are not the only ones at risk. In one case, a physician was ordered to participate in the Diversion Program as a term of probation. However, he was not tested at all for the first three months of participation. The Diversion Program thought the Probation Unit was testing him, and the Probation Unit thought the Diversion Program was testing him. Nobody was testing him — and nobody knew that except the participant. Diversion assumed that Probation was testing him and that — because it received no positive tests — there were no problems. Then the Diversion Program received a telephone call from an emergency room attending physician who told Diversion that the participant had been brought into the ER passed out due to acute intoxication. At the time of this incident, that participant was permitted to practice medicine. He almost died because nobody was testing him, and nobody knew that nobody was testing him.

Even when the required minimum levels of testing are completed, in some circumstances these requirements are insufficient for purposes of detecting a participant's substance abuse. The human body can flush alcohol from the system fairly quickly, such that — in the words of one knowledgeable interviewee — "you can drink a six-pack on Sunday night and test clean on Monday." Some powerful drugs dissipate quickly from the system and are generally not detected. There are simply no (or inadequate) tests capable of detecting other drugs of choice. We found the following examples in Diversion Program files:

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[444] *See* 1985 Auditor General Report, *supra* note 428, at 17 ("[case managers] are not collecting urine samples in accordance with the diversion program's policies").

[445] *See* 1986 Auditor General Report, *supra* note 430, at 7 ("[case managers] did not collect all the urine samples for 71 percent of the participants in our sample").

■ A participant's admitted self-use of prescription drugs obtained from a hospital pharmacy over a five-month period extending from November 2002 to March 2003 and also during July and August 2003 was not detected even though the participant was consistently tested four times per month during both of these periods.

■ An employer detected a participant's diversions of Fentanyl during a routine hospital audit and then tested the participant positive. A Diversion Program specimen collected the next day did not test positive. Subsequently, about one year later, this same participant was arrested for driving while under the influence of alcohol. A Diversion Program specimen collected the next day did not test positive.

■ An employer investigation identified evidence of a participant's self-reported diversions of prescription drugs over a ten-month period that went undetected by the Diversion Program even though the participant was usually tested four times per month throughout this period. In one of these months, specimens were collected from the participant on the 14th, 17th, 24th, and 27th. The participant diverted IV-Demerol on the 25th and 30th. During the next month, the participant's four specimens were all collected by the 17th day of the month. The participant diverted IV-Demerol three times during the next ten days.

These examples illustrate the critical importance of testing *at least* the minimum number of times required pursuant to current Diversion Program policy. In contrast to these policies, current practices of the Diversion Program generally result in a frequency of testing that rarely exceeds these minimum requirements and, oftentimes, falls far short.

Even in cases where participants are being tested the required number of times, the above-described problems of flawed recordkeeping, delays in receiving test results, and absence of sufficient positive controls over the Diversion Program's urine collection system cast doubt on the integrity of the system. At the very least, the Program is unable to demonstrate that participants are complying with the terms of their contracts. At worst, the public is being exposed to physicians who may be practicing medicine while impaired due to undetected relapse into drug and/or alcohol use — a clear violation of Business and Professions Code sections 2001.1, 2229, and 2340.

The Monitor alerted Diversion Program and MBC management to the confluence of these problems within the Program's urine collection system in June 2004, and management immediately convened a small working group consisting of two Board members, MBC and Diversion staff, and representatives of the Monitor team. The working group has met three times and is working toward resolution of these problems.

(2) It is unclear whether the case managers are attending group meetings as required by Diversion Program policy. The Program's case managers represent another "monitoring"

mechanism of the Diversion Program.[446] The *Diversion Program Manual* requires case managers to attend each group meeting in his/her geographic area once a month in order to observe both the group facilitators and the participants.[447] Case managers are required to report their group meeting attendance in monthly reports to the Program Administrator.[448] However, few case managers file monthly reports as required. In August 2004, we looked at the Program Administrator's binders of CM monthly reports for 2003 and 2004. One case manager submitted one monthly report in 2003 and none in 2004, and another submitted no monthly reports in 2003 and two in 2004 — so there is no documentation as to whether they have attended group meetings as required by Program policy. Three other case managers submitted monthly reports fairly regularly during both years; two of those CMs reported attending the meetings of only one or two groups in their locale per month, while the other attended the meetings of five to seven groups per month. And, for long periods during 2003 and 2004, the policy requiring case managers to attend group meetings of each group in his/her locale at least monthly was suspended for case managers in "impacted" areas of the state — those with 70 or more cases.

The Program constantly states that its case managers — one of the few components of the Diversion Program that has not been performed by the private sector — are one of its key monitoring mechanisms. Yet the problem of inconsistent or inadequate contact by case managers with participants was identified by the Auditor General as far back as 1982,[449] 1985,[450] and 1986.[451] The problem of inadequate reporting by case managers and inadequate supervision of the case managers

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[446] Medical Board of California, *Physician Diversion Program* (March 2000) at 2 ("[t]he role of the case managers is to ensure that the participants who are assigned to them comply with the provisions of their Diversion Agreements and are solidly in the recovery process. The Case Manager has direct contact with each participant every 4–8 weeks").

[447] Medical Board of California, *Diversion Program Manual* (undated) at Ch. 2, p. 5 ("CMs attend the facilitators' group meetings once a month to observe the facilitators and participants"). Actually, the Manual is inconsistent on this point. On another page, the Manual states: "The CM is to attend each group meeting in his geographic area at least every two months." *Id*. at Ch. 1, p. 6 When questioned about this inconsistency, the Program Administrator clarified that the statement in Chapter 1 at page 6 is an error. Her expectation is that case managers must attend a meeting of every group in his/her locale once every month; however, case managers in "impacted" areas of the state must attend meetings of a group of each facilitator once every two months. Interview with Diversion Program Administrator (Mar. 4, 2004).

[448] Medical Board of California, *Diversion Program Manual* (undated) at Ch. 1, p. 12.

[449] *See* 1982 Auditor General Report, *supra* note 427, at 36 ("the frequency of the [case managers'] contacts with physicians varies . . . . [F]requency of contact varies widely").

[450] *See* 1985 Auditor General Report, *supra* note 428, at 9 (for 24 participants studied, case managers made only 150 (57%) of the 262 visits required).

[451] *See* 1986 Auditor General Report, *supra* note 430, at 7 (case managers "did not visit 81% of the participants in our sample for periods ranging from approximately three months to seven months").

by the Program Administrator was identified by the Auditor General in 1985[452] and 1986.[453] Little has changed.

(3) Worksite monitoring and reporting is deficient. The Program assures the public that if impaired physicians are permitted to practice medicine, they are "monitored" by non-impaired physicians.[454] However, the Program has set forth no workable definition of the duties, qualifications, or expectations of a "worksite monitor." Although some Diversion Program materials convey the idea that participants are "supervised" while practicing medicine, that is not the case. The *Diversion Program Manual* contains a semblance of the duties of a "hospital monitor," but it is hardly specific or reassuring. According to the *Manual*, "the hospital monitor's responsibility is to observe the participant as frequently as possible and to assess to the best of his/her ability whether the participant is impaired as a result of drugs, alcohol and/or mental difficulties; to provide written reports on preprinted forms regarding the progress of the participant every three months and to assess if there are any changes in attitudes and behavior. Both positive and negative changes should be reported. The monitor is to notify the case manager if he feels a urine specimen is needed or he may collect the urine specimen himself." The statement contains no requirements that the worksite monitor actually be onsite at the same time as the participant, supervise the participant in any way, or even meet with or talk to the participant. The statement also sets forth no qualifications or criteria for someone functioning as a "worksite monitor"; it does not even require the monitor to be a physician. In fact, the Program Administrator stated that, on occasion, the Program is required to approve a physician's office manager — someone who is hired and fired by the participant — as the worksite monitor.

Additionally, people functioning as worksite monitors are not consistently filing quarterly reports as required by the Program. A complete, or nearly complete, set of quarterly worksite monitoring reports was present in the central file for only seven of the twenty imminent completion cases that we reviewed. In most of the other thirteen cases, there are only a few quarterly worksite monitoring reports in the central file. In many cases, participants have been allowed to increase their practice hours or — in one case — resume practice on a full-time basis notwithstanding continuing deficiencies related to the submission of quarterly worksite monitoring reports.

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[452] *See* 1985 Auditor General Report, *supra* note 428, at 18 ("[case managers'] reports are not always complete or accurate"; "while the diversion program's [case managers] have been deficient in monitoring participants, the program's management has been similarly deficient in monitoring the performance of the [case managers]").

[453] *See* 1986 Auditor General Report, *supra* note 430, at 19–20 ("[d]eficiencies persist in [case managers'] performance because supervision of the monitoring activities of [case managers] has been limited. For example, the program manager does not check the accuracy of [case managers'] recordkeeping . . . . The program manager also does not ensure that visits to participants recorded by [case managers] on their monthly logs are documented in writing").

[454] Medical Board of California, *Physician Diversion Program* (March 2000) at 2 ("[p]articipants are closely monitored while in the Diversion Program. A wide variety of monitoring components [including "worksite monitor(s)" and "hospital monitor(s)"] is used in order to ensure patient safety and provide strong support for the physician's recovery").

It is possible that these participants' worksite monitors have submitted quarterly reports more often, but that the Diversion Program's case managers have not always forwarded copies of the reports to the central file. In an effort to determine the extent to which this has occurred, in May 2004 we asked the case managers to provide us with a listing for each of these participants showing the dates of all reports contained in their personal files. To date, none of the case managers has responded to this request.

The quarterly worksite monitoring reports constitute a promise made by the Diversion Program to the public, and are a key mechanism for communication between the worksite monitors and the case managers. It is our understanding that the case managers may sometimes telephone worksite monitors and obtain verbal reports when written reports are not submitted. In addition to asking the case managers to provide us with a listing of the dates of all reports contained in their personal files, we also asked them to list the dates of any verbal reports that they received in lieu of the written reports. To date, none of the case managers has responded to this request.

Nothing came to our attention during the course of our review of the twenty imminent completion files to indicate that participants have been practicing without appointment of an approved worksite monitor. However, it does not appear that Diversion Program staff pay much attention to participant noncompliance with the associated quarterly reporting requirement. When continuing noncompliance with the quarterly reporting requirement is detected, the only corrective action usually taken is to remind the participant that they are supposed to comply with the requirement. It does not appear that participants are ever sanctioned or penalized in any way for failure to comply with this provision of their Diversion Agreement. For example, we found no instances where restrictions were placed on the number of hours per week a participant was permitted to practice due to deficiencies related to the submission of quarterly worksite monitoring reports. Conversely, we found several cases were participants were permitted to increase their practice hours notwithstanding continuing compliance deficiencies related to submission of quarterly monitoring reports as well as deficiencies related to fulfillment of other administrative requirements (for example, submission of quarterly therapist reports (see below) and participant semi-annual reports).

Although Appendix C to the *Diversion Program Manual* displays a form letter sent to hospital well-being committee chairs and a document entitled "Worksite Monitor Responsibilities," neither of those documents sets forth any required qualifications, criteria, or standards for the worksite "monitoring" that is promised to the public by the Diversion Program. The Program's failure to adequately define the duties, qualifications, and functions of "worksite monitors" and the

failure of worksite monitors to submit quarterly reports were identified by the Auditor General in 1982,[455] 1985,[456] and 1986.[457] Little has changed.

(4) Treating psychotherapist reporting is deficient. The Diversion Program assures the public that impaired physicians are also monitored by treating psychotherapists who are required to file quarterly written reports with the Program.[458] However, this monitoring requirement is not being satisfied. Neither the case managers, the Program Administrator, nor the DECs (which annually review all Program participants) are ensuring that quarterly treating psychotherapist reports are filed.

Of the twenty imminent completion cases that we reviewed, eleven participants were required to receive individual therapy. In most cases, this requirement was imposed immediately upon the participant's acceptance into the Program and has continued in force since that time. In a few cases, this requirement was not imposed until some time after the participant was accepted into the Program or the requirement was deleted prior to the participant's completion of the Program. The quarterly reports help to assure that the participant actually fulfills his individual therapy requirements and is progressing in treatment. The treating therapist also helps program staff to detect pre-relapse behavior and relapses.

As shown in Exhibit XV-A below, the central file records available to us indicate that participants with this requirement have actually complied with the quarterly therapist reporting

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[455] *See* 1982 Auditor General Report, *supra* note 427, at 38–39 (Program policy requires participants to "work in an environment that permits his or her practice to be overseen by another physician. The purpose of this restriction is to reduce the opportunity for the physician to repeat incompetent acts or to return to alcohol or drug abuse . . . . [However,] supervisors were not submitting required reports on the physicians' performance in 17 of the 18 cases, 94 percent").

[456] *See* 1985 Auditor General Report, *supra* note 428, at 20–21 ("[t]he practice monitors told us that they do not know what their responsibilities are. They said that they do not receive a copy of the participants' treatment plans, which outline the duties of practice monitors. Furthermore, the [case managers] are not routinely contacting practice monitors to inform them of their responsibilities . . . . These problems regarding the responsibilities of practice monitors result, in part, because the diversion program does not have a detailed description of the duties of a practice monitor").

[457] *See* 1986 Auditor General Report, *supra* note 430, at 3–4 and 15–18. Here, the Auditor General discussed "condition monitors," defined as "physicians or supervisors who work in the same building as the participants, and . . . are responsible for observing the participants' condition while the participants practice medicine." The Auditor General found that the case managers "are not contacting participants' condition monitors often enough . . . 12 (86%) of the 14 condition monitors assigned to participants were not contacted by [case managers] as often as policy requires." Also, "[case managers] are not ensuring that condition monitors sign and submit the letters that explain the condition monitors' responsibilities."

[458] Medical Board of California, *Physician Diversion Program* (March 2000) at 2 ("[p]articipants are closely monitored while in the Diversion Program. A wide variety of monitoring components [including "ongoing psychotherapy" and "progress reports: therapists, monitors, treating physicians"] is used in order to ensure patient safety and provide strong support for the physician's recovery"). *See also* Medical Board of California, *Diversion Program Manual* (undated), Ch. 1 at p. 8 (treating psychotherapist quarterly report requirement).

requirement on only a minimal basis, or not at all. For example, there are no treating therapist quarterly reports in the central file for four of the participants. In all of the remaining cases, the central file contains fewer than one-half of the required number of reports.

Ex. XV-A. Treating Therapist Quarterly Report Submissions — Imminent Completion Cases

Speciality	Accepted Into the Diversion Program	Required Number of Quarterly Reports	Actual Number of Quarterly Reports
Emergency Medicine	September 1999	18	8
Internal Medicine	September 1999	13	3
Family Practice	September 1999	11	5
Anesthesiology	September 1999	14	6
Anesthesiology	October 1999	18	None
Pediatrics	October 1999	18	3
OB/GYN	November 1999	11	None
Radiology	April 2000	16	None
Surgery	May 2001	11	2
Psychiatry	April 2000	16	4
Otolaryngology	January 2000	13	None

It is possible that these participants' therapists have been submitting quarterly reports more often than indicated above, but the Diversion Program's case managers have not always forwarded copies of the reports to the central file. In an effort to determine the extent to which this has occurred, in May 2004 we asked the case managers to provide us a listing for each of these participants showing the dates of all reports contained in their personal files. None of the case managers responded to this request.

We were unable to determine, within the scope of this review, the extent to which participants were actually completing individual therapy as required by their Diversion Program Agreements. The presence of some quarterly reports in cases where they are not regularly submitted suggests that most of the participants are probably complying with the treatment requirements. Of concern, however, are those cases where there are no quarterly reports for the participant. In these cases, it is possible that the participant is not complying with the treatment requirements.

Again, in most cases, it does not appear that Diversion Program staff pay attention to participant noncompliance with the quarterly therapist reporting requirement. When continuing

noncompliance with the reporting requirement is detected, the only corrective action usually taken is to remind the participant that he is supposed to comply with the requirement. Given the limited extent to which participants comply with this reporting requirement, it is unclear how Diversion Program staff monitor and track participant compliance with the underlying treatment requirements. It does not appear that participants are ever sanctioned or penalized in any way for failure to comply with this provision of their Diversion agreement.

b. The Program is so understaffed that staff could not correct the failures in its monitoring mechanisms even if they knew about them.

As described above, the Diversion Program has suffered a 22% increase in participation with no increase in staff over the past ten years. Beginning in March 2002, the caseloads of several case managers in certain parts of the state were deemed so excessive that Program management curtailed entry into the Program by participants who would be served by those case managers and simultaneously lessened the participant monitoring expected of those case managers.[459]

Excessive caseloads for the case managers is only one symptom of the understaffing of the Diversion Program. In the Monitor's view, there is significant understaffing at all levels of the Diversion Program. As described above, the Board — as a result of the Auditor General's 1982 report — acknowledged that it is not possible for one administrator to (1) supervise the case managers and support staff, (2) make Program decisions, and (3) engage in overall program oversight. Thus, the Board agreed to hire a deputy program manager to supervise the case managers. That deputy program manager was hired at the time of the Auditor General's 1985 report, but that person was apparently ineffective because the Auditor General found significant deficiencies with the performance of the case managers in both the 1985 and 1986 reports. That deputy manager position was reclassified to a lower-level position in the early 1990s, and the Program Administrator is back to handling functional supervision, program oversight, and program development — a burdensome combination of duties which one person cannot competently handle alone. Many issues referred by the Diversion Committee to staff for study — or to the Liaison Committee to be assisted by staff — simply fall through the cracks and are never resolved because of the paucity of analytical staff.[460]

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[459] *See supra* notes 441–42 and accompanying text.

[460] Over the past three years, the Monitor has observed the Diversion Committee refer — either to staff or to the Liaison Committee — the following issues: (1) how to protect the public from self-referred participants who contact the Diversion Program, admit to a serious problem, and then walk away; (2) the Program's failure to track "graduates" in any way to determine whether the Program is effective; (3) the criteria and qualifications for "evaluating physicians" who examine prospective participants in the Diversion Program; (4) the development of regulations providing guidelines for when the Program may order a participant to undergo a competency exam; and (5) ironically enough, whether the Diversion Program is sufficiently staffed. None of these issues has ever been resolved.

In our observation and based on our reviews of Diversion Program files, the case managers and the Program Administrator are so overloaded that all they are able to do is react to relapses. The case managers do not adequately monitor their caseloads — as evidenced by missing documentation described above that should be in participants' files but is not. CMs do not enter all required data in the DTS, nor do they forward all required materials to Sacramento. Neither the case managers nor the Program Administrator were aware of any of the problems we found with the urine collection system described above. The four Sacramento-based support staff cannot possibly keep up with their Program-related work responsibilities (including the calendaring and staffing of all DEC meetings all over the state) plus the work necessary to accommodate the needs of the Diversion Committee, the Liaison Committee, and the Division of Medical Quality.

Of particular importance, the Collection System Manager position is significantly understaffed. Although the *Diversion Program Manual* promises a dedicated CSM position responsible for the generation of random testing dates for all participants and the communication of that list to all collectors, GFs, and CMs, "oversight and coordination for the collection system process," and "the integrity of the collection system,"[461] the individual currently serving as the CSM is able to spend only about two hours per month on CSM duties. All the CSM is able to do is generate the list of dates and send it out. As described above, no one ensures that all active participants are included in the master collection schedule; all participants are scheduled for the required number of tests, per the Diversion Program "frequency of testing" policy; collections are actually completed on the random date assigned by the CSM; the same number of collections is completed as is scheduled for each participant; collected specimens are received at and processed by the laboratory; test results are correctly downloaded and appended to each participant's record in the DTS; and collectors submit a monthly report of all collections as required by Program policy.

Because of the Program's significant understaffing and the imposition of the hiring freeze, the Program Administrator admitted that she is hesitant to discipline or even warn case managers who do not adequately monitor their caseloads, enter information onto the DTS, and/or forward important documentation of Program requirements to Sacramento for filing in the participant's master file. Having looked at over 60 Diversion Program participant files (which is about one-fourth of the entire population of participants), the Monitor can state without hesitation that the Auditor General's 1982 criticism of Diversion Program recordkeeping — "records on each participant are scattered among three separate files"[462] — is still true in 2004. And that recordkeeping is essential

[461] Medical Board of California, *Diversion Program Manual* (undated), Ch. 5 at 3.

[462] *See* 1982 Auditor General Report, *supra* note 427, at 40.

to informed decisionmaking that must occur very quickly to protect the public in the event of relapse.[463]

The Diversion Program must be adequately staffed with persons of adequate qualifications. The Program Administrator should be supported by two administrative positions — one to supervise the case managers to ensure that programmatic policies and procedures are followed, and to assist the Administrator in making critical decisions regarding participation, treatment, and the practice of medicine by participants; and another to supervise the support staff and to ensure that the needs of CMs, GFs, DECs, the Diversion Committee, and DMQ are met. Case managers should have no more than 50 cases each; each case manager should be required to ensure that all participants comply with all requirements of their Diversion Program contracts, and that all required information is both entered onto the DTS and forwarded to headquarters for filing in participants' master files. The CSM function must be staffed on a full-time basis. The Program should have a sufficient number of support staff to accommodate the needs of the CMs, GFs, DECs, the Diversion Committee, and DMQ.

Having said that, the Monitor must emphasize that the mere addition of staff alone will not solve the Diversion Program's problems. As described above, the Program lacks significant internal quality controls to ensure that all of its various monitoring mechanisms are functioning to detect relapse or pre-relapse behavior. If those monitoring mechanisms fail (as they have), and if there are inadequate internal quality controls to detect that failure (as there are), both the physicians in the Diversion Program and the public whose safety is the "paramount" priority of the Medical Board are exposed to serious risk. It is abundantly clear that the Program has functioned without adequate internal controls for 24 years. These controls must be designed, installed, and adequately staffed.

2. The Program suffers from an absence of enforceable rules or standards to which participants and personnel are consistently held.

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[463] Our review of the records in Diversion Program participants' files revealed a number of other defects attributable to inadequate recordkeeping practices and/or the failure of Program staff to insist on compliance with Program policies. For example, we found numerous files in which Diversion Program agreements were inaccurate, incomplete, or unsigned by both the participant and the Program. We also found wide variability in the use of Diversion Agreement amendments. Diversion Agreements are frequently amended when the Program changes a participant's practice restrictions, frequency of required attendance at Diversion Program group or AA meetings, frequency of urine collections, etc. There was no consistency in the types of Agreement changes that were documented in formal "amendments" to the Agreement vs. a "note to the file." Additionally, it was quite unclear who was approving these changes — a DEC, the Program Administrator, or other Program staff. The end result of these deficiencies is confusion about which terms and conditions are in force at any particular point in time. Additionally, and as noted above, we found numerous errors and inconsistencies in the Program's DTS computerized database; some of these are due to human error, while others are due to the failure of CMs to consistently enter all data they are required to enter into the DTS. Finally, because the Program's files are so incomplete, the Quarterly Quality Review reports discussed at each quarterly meeting of the Diversion Committee contain errors and omissions which prevent the Committee from adequately supervising the performance of the Program.

Compounding the failure of its monitoring mechanisms and understaffing problems described above, the Diversion Program is plagued by an almost complete lack of hard-and-fast, enforceable rules, standards, or expectations to which participants are held. The Diversion Program's decisionmaking is characterized by an unacceptable "case-by-case basis" mentality which promotes inconsistent decisionmaking and serves the interests of neither the participants nor the public.

a. The Diversion Program's statutes and regulations are skeletal at best, and set forth few enforceable rules, standards, or expectations for either the Program or its participants. The Diversion Program's statute was enacted in 1980 and has been rarely amended since then; DMQ's regulations implementing that statute are — for the most part — nonsubstantive restatements of the statute. None of the monitoring mechanisms described above — not the urine testing, nor the requirement that case managers regularly and personally observe both the group facilitators and the participants, nor the requirement of group meeting attendance, nor the worksite monitor requirements, nor the treating psychotherapy reporting — are mentioned in, much less governed by, statute or regulation. All of these monitoring mechanisms are contained in an unenforceable "procedure manual" that has rarely if ever been scrutinized by DMQ — which is statutorily responsible for administration of the Program — or even the Diversion Committee.

b. The *Diversion Program Manual* — which is unenforceable — sets forth no clear rules and no mechanisms to ensure standardized and consistent decisionmaking about potentially dangerous physicians. As described above, Diversion Program decisionmaking is excessively fragmented. If and when a relapse occurs — a relapse into drug or alcohol use by a physician who is practicing medicine with a full and unrestricted license and who may see dozens of patients each day, that event (which is detected by the Program days or even weeks after the test) sets in motion a complex and time-consuming chain of communications between various Program personnel (the CM, GF, the DEC consultant assigned to the participant, and perhaps the entire DEC which may be polled by telephone) and the participant, the lab, the participant's worksite monitor and/or hospital monitor, and the hospital well-being committee. As described above, these contributors to the ultimate Program decision are hampered by "records on each participant . . . scattered among three separate files" — participant files maintained at headquarters which lack critical documentation, a Diversion Tracking System that is used inconsistently by case managers and fails to capture all relevant information, and documentation of Program requirements that is either on location with the case managers or does not exist at all because it has not been submitted.

These individuals have no clear standards to guide their decisionmaking — a dynamic which can lead to inconsistent decisionmaking. The "rules" that are set forth in the *Diversion Program Manual* and purport to govern day-to-day operational procedures have been developed by prior staff with little or no input from the Division of Medical Quality, the Diversion Committee, or any of the Committee's predecessor task forces. Several of those "rules" are in fact "underground regulations" that should be adopted as regulations pursuant to the Administrative Procedure Act.

Each DEC operates in a vacuum; no standards exist to guide their consideration of individual participant matters to ensure that their recommendations are fair, consistent, and protective of the public interest. No DEC knows how another DEC has acted in a similar matter. No caselaw, precedent, or standards exist anywhere to guide them. In fact, no minutes of DEC meetings are ever taken.[464] The minutes of Liaison Committee meetings indicate an occasional concern that the various DECs are treating similar substantive issues differently, or procedurally functioning differently from each other. Under current law, the Program Administrator (not the DEC) is supposed to make final decisions and is thus in a position to impose consistency on various DEC recommendations — but the Program Administrator rarely if ever overrules a DEC recommendation.[465]

c. There is no consistently applied and enforceable rule regarding consequences for relapse. The Diversion Program's statute sets forth no consequences for relapse; instead, it directs the Division of Medical Quality to "establish criteria for the . . . termination of physicians" from the Program.[466] In turn, the Division has adopted a regulation authorizing the Program Administrator to terminate a physician's participation "for any of the following reasons: (a) [t]he physician has failed to comply with the diversion agreement, including but not limited to, failure to comply with the prescribed monitoring or treatment regimen, use of alcohol or other unauthorized drug; or refusal to stop practice when directed to do so . . . ."[467] This regulation is close to meaningless in practice. Participants relapse every day and are not terminated. Participants routinely fail to comply with their Diversion Program agreements in all sorts of ways — both significant and insignificant — and are not terminated. Of most critical importance, however, is the Division's failure to address the consequences for relapse. As noted above, relapse is expected during recovery, and it may not be reasonable to fashion a "one-strike-you're-out" policy. However, the Diversion Program has unilaterally fashioned (without input from DMQ) a "three-strikes-and-you-may-be-out" policy which is unenforceable.[468] Further, this "rule" is not consistently applied. In our review of twenty recent

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[464] Counsel to the Board have advised the Program not to take or retain "minutes" of DEC meetings which might be subpoenaed. Instead, the Program Administrator and analyst take notes on each case, which notes are then destroyed after staff implements the directives recorded in those notes.

[465] Interview with Diversion Program Administrator (July 26, 2004). Program staff note that the Program Administrator attends every DEC meeting and is in a position to inform one DEC how another DEC has treated a similar case. This may be true, but — for purposes of consistent decisionmaking across DECs and over time — it assumes that the Program Administrator serves for a lengthy tenure and has perfect memory. The Diversion Program has had two Administrators and one Acting Administrator in the past four years.

[466] Bus. & Prof. Code § 2350(a).

[467] 16 CAL. CODE REGS. § 1357.5.

[468] As noted above, both Diversion Program manuals include a "rule" stating that "a participant in the Diversion Program will be considered for termination when the participant has more than three relapses while in the Diversion Program." *See supra* text at note 416 and note 416. This is one example of arguable "underground rulemaking" contained in the Diversion Program's policy and procedure manuals.

relapse cases, we found at least six cases in which the participants had relapsed at least four times before even being considered for termination, including the following examples:

- A participant was referred to the Diversion Program during mid-1998 pursuant to an SOU. The participant was permitted to remain in the Diversion Program following three relapses during November 1998 (collection tested positive for cocaine), December 1999 (collection tested positive for cocaine and alcohol), and December 2000 (self-reported using alcohol after missing work and group meetings). The participant subsequently relapsed a fourth time during April 2003 (collection tested positive for methamphetamine) and concurrently quit providing specimens and attending group meetings. The participant was not formally terminated from the Program until more than two months after the fourth relapse was detected.

- A participant was ordered into the Diversion Program during November 2000 as a condition of probation. At that time, the participant had already been involved with the Diversion Program for nearly two years. The participant missed several urine tests during the evaluation phase and also was noncompliant with Program requirements for a 2.5-year period following acceptance into the program (for example, the participant provided only two urine specimens over a 24-month period due to an inability to pay associated fees, failed to submit quarterly therapist reports, failed to submit semi-annual reports, and was out of compliance with continuing education requirements). Notwithstanding these continuing compliance deficiencies, during April 2003 the participant was authorized to return to work on a part-time basis. Following this, the participant continued to be out of compliance with Program requirements. In November 2003, the participant tested positive for cocaine, but was allowed to continue participating in the Program. In February 2004, the participant tested positive for Vicodin. Three months later, during May 2004, the participant was terminated from the Diversion Program. In total, this participant was involved with the Diversion Program for nearly six years and, as best we can determine, never achieved monitored sobriety for a sustained period or otherwise complied with Program participation requirements.

- A participant was referred to the Diversion Program during June 2001 pursuant to an SOU. The participant was permitted to remain in the Diversion Program after four relapses during October 2001 (tested positive for alcohol), February/March 2003 (tested positive for alcohol on two different occasions), December 2003 (tested positive for alcohol), and March 2004 (tested positive for alcohol). The participant also missed a scheduled collection during June 2001, was unavailable to be monitored for an extended period of time during mid-2003 due to participation in an unauthorized activity, and submitted a diluted specimen during January 2004. The participant was terminated from the Diversion Program one month after the fourth relapse was detected. The stated basis for the termination was the participant's failure to begin recommended inpatient treatment, suggesting that the participant otherwise would have been permitted to continue in the Program.

- A participant self-referred to the Diversion Program during November 2002. The participant relapsed during August/September 2003 (tested positive for Meperidine and Fentanyl), ceased taking Naltrexone without notifying the case manager, overmedicated a patient, was observed carrying unnecessary medications on his cart, missed urine collections and, after mid-October 2003, stopped attending group meetings. The participant was not formally terminated until early January 2004 (more than three months after he had stopped complying with Program requirements).

In 1982, the Auditor General detailed six cases in which participants egregiously violated the terms of their Diversion contracts but were not terminated from the Program; according to the Auditor General, "[t]hese deficiencies result from a lack of established standards and guidelines for terminating participants. In particular, the Board has not clarified the requirement that a physician be terminated from the program when that physician is deemed too great a risk to public health, safety, or welfare, especially when the physician is either under the influence of alcohol or drugs or mentally or physically disabled while caring for patients."[469] In 1985, the Auditor General detailed three matters where the participant repeatedly violated significant terms and conditions of the contract and should have been suspended from the practice of medicine and/or terminated from the Program but was not; the Auditor General concluded that the Medical Board must "[s]pecify for the program manager of the diversion program the kinds of noncompliance that warrant suspension or termination," and "develop a reporting system for the diversion program that will provide the medical board with enough information to supervise the program properly."[470]

Over 20 years later, DMQ has still failed to establish meaningful and enforceable standards for the handling of relapse by Diversion Program participants and for termination from the Program — apparently preferring to delegate to DECs and the Program Administrator a "case-by-case" approach. The Monitor appreciates the difficulty of fashioning a "one-size-fits-all" rule regarding relapse, but it seems patently unfair to both physicians and consumers that chronic relapsers who repeatedly and egregiously violate the terms of their Diversion contracts remain in the Program while other physicians genuinely seeking help are denied admission because of resource constraints and the Program's unwillingness to terminate the chronic relapsers.

d. The Diversion Program's statutes permit repeat offenders "too many bites of the apple." Related to the concern expressed above about DMQ's failure to establish meaningful standards for relapse and termination from the Program is another dynamic that we found in our review of Diversion Program files — and that remains unaddressed by statute, regulation, or policy. This dynamic involves a participant's repeated entry into, withdrawal or termination from, and

[469] *See* 1982 Auditor General Report, *supra* note 427, at 43.

[470] *See* 1985 Auditor General Report, *supra* note 428, at 22–32.

reentry back into the Diversion Program. This "too many bites of the apple" syndrome works as follows:

Bite #1: A physician self-refers into the Diversion Program, then withdraws or is terminated for noncompliance. The Program can do nothing unless a DEC makes a finding that the physician constitutes a "threat to the public health or safety" under section 2350(j)(3).

Bite #2: MBC receives a complaint, a DUI arrest or conviction, or section 805 report against that same physician. Enforcement investigates the matter and diverts the physician into the Diversion Program under a statement of understanding (SOU) under section 2350(b). The physician is again in the Diversion Program; this time, his participation is known to enforcement but it is still concealed from the public because SOUs are not disclosed on MBC's Web site or in any other way. The physician withdraws or is terminated from noncompliance. This time, there is no "threat" assessment because the physician is in Diversion under an SOU, so he is referred to enforcement.

Bite #3: This time, enforcement likely files an accusation, which fact is disclosed on MBC's Web site. The physician stipulates to probation, including required participation in the Diversion Program. That term of probation is not included on MBC's Web site because of CAS limitations (see Chapters V and XIII). The physician withdraws or is terminated for noncompliance.

Bite #4: HQE files a petition to revoke probation (and possibly a petition for ISO if HQE can prove the physician is currently using drugs or alcohol). After hearing, the ALJ recommends revocation of the license. DMQ revokes, stays the revocation, and places him on probation — one term of which is (again) required participation in Diversion. The physician withdraws or is terminated for noncompliance.

Bite #5: This "bite" will be a repeat of Bite #4 unless DMQ finally revokes the license or the DEC and the Program Administrator refuses to admit him into the Diversion Program (both events are somewhat rare).

This is not a hypothetical issue. We have found a number of cases in which chronic relapsers who repeatedly enter and are repeatedly terminated from the Program are repeatedly readmitted to the Program. Two examples are illustrative:

- While undergoing inpatient substance abuse treatment in 1997, 1998, and 1999, a physician was ordered by the Board to participate in Diversion in July 1998; the physician was unsuccessfully terminated in June 1999. In September 1999, HQE filed an accusation and a petition

for ISO after the physician collapsed on duty as a result of abuse of Vicodin, Demerol, and Xanax. A partial ISO imposing therapy and practice restrictions (not a suspension) was granted on September 19, 1999. Following the filing of a supplemental accusation in November 2000, DMQ placed the physician's license on probation and ordered the physician to return to Diversion. In February 2002, a DEC denied admission to Diversion because of noncompliance during the evaluation phase; Probation was not notified of the DEC's decision, and assumed the physician was in the Diversion Program. In July 2003, HQE filed a petition to revoke probation (because the physician was not in Diversion), and the physician reapplied for admission to Diversion. This time, the DEC accepted the physician's application and admitted the physician into the Program. HQE's petition to revoke probation is pending.

■ After undergoing inpatient treatment in 1997, 1998, and 1999, this physician was unsuccessfully terminated from the Diversion Program in April 2000. As the result of a complaint to enforcement, the physician was referred back into Diversion under an SOU in July 2000. The physician resumed practice without authorization and, in December 2000, the physician's application for admission into Diversion was denied. During September 2001, the participant was ordered into Diversion under the terms of a DMQ-approved stipulation. Although the physician relapsed on alcohol on July 17, 2003, the Program permitted the physician to continue practicing medicine. On July 28, 2003, the physician tested positive for Demerol, and was terminated from Diversion on August 8, 2003.

Nothing in the Diversion Program's statutes, regulations, or policy manual addresses this issue or prevents this waste of the Program's limited resources. In light of the Program's budget constraints, understaffing, and the significant absence of internal controls described above, it is unfair to subject the public to a repeat offender who is able to manipulate the system and remain licensed. That physician's space in the Diversion Program would be better used by someone more committed to recovery.

DMQ must shoulder its statutory duty and establish clear standards for several aspects of the Program. It is fair to say that DMQ has never meaningfully implemented the Legislature's directive to "establish criteria for the acceptance, denial, or termination of physicians" from the Diversion Program.[471] The Division has adopted some regulations, but they are merely restatements of the statute and/or commonsense, circular, and fairly nonsubstantive prescriptions.[472] The Division has never meaningfully implemented the Legislature's directive to "establish criteria for the selection

[471] Bus. & Prof. Code § 2350(a).

[472] For example, a physician can be terminated from Diversion under section 1357.5, Title 16 of the California Code of Regulations, if he has done anything to warrant denial of his application for admission under section 1357.4, Title 16 of the California Code of Regulations.

of evaluating physicians and surgeons or psychologists who shall examine physicians and surgeons requesting diversion . . . ."[473] This leads the Monitor to the next major concern.

3. Contrary to statute, the Division of Medical Quality has never taken "ownership" of or responsibility for the Diversion Program.

As noted above, state law requires DMQ to administer the Diversion Program and oversee its functioning.[474] MBC's Diversion Program is one of only four in the nation to be housed directly within a state medical board — subject to its direct supervision and oversight. One must assume that the purpose of this in-house structure is to enable members of the Medical Board to affirmatively oversee the Diversion Program to ensure that the public is protected from impaired physicians. However, this has not happened. Instead, in 1982, the Division of Medical Quality effectively delegated its authority over the Diversion Program to the Liaison Committee — which has no statutory existence or authority — and to the staff of the Diversion Program, which in the past has interpreted Liaison Committee directives and recommendations as orders, and has implemented them without DMQ or Diversion Committee review.[475]

The Auditor General reports of the 1980s universally found that the Division has failed to adequately supervise and oversee the Diversion Program.[476] The 1985 report could not be more

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[473] Bus. & Prof. Code § 2350(h). *See supra* note 398. Instead, the Division punted this duty to the Liaison Committee, which presented some draft criteria to the Diversion Committee at its February 2001 meeting. The Chair of the Diversion Committee strongly objected to some of the exceptions to the requirements, and sent the criteria back to LCD for more work. The LCD did not come back with an amended version until the Committee's January 2002 meeting, when legal counsel objected to them and LCD withdrew them for "further work." These criteria have never again appeared on any agenda of the Diversion Committee or the Division of Medical Quality.

[474] Bus. & Prof. Code § 2346.

[475] In 1999 documents, the Liaison Committee noted that it had engaged in numerous activities and made many recommendations regarding the functioning of the Diversion Program over the prior five years. These activities include a report and recommendation on the Program's urine testing program (Oct.16, 1998); a recommendation on elements which should be included in the clinical evaluations of physicians applying for or participating in the Program (Feb. 25, 1998); a report specifying the role and responsibilities of the DEC member who is serving as a case consultant, plus two measures for identifying whether a case consultant is carrying out the intended function (Aug. 21, 1996); and the adoption of a policy in 1994 requiring group facilitators to maintain a current file on each participant. Liaison Committee to the Medical Board's Diversion Program, *Testimony before the Medical Board's Diversion Task Force* (Jan. 20, 1999) (on file at CPIL); *see also* Liaison Committee to the Medical Board's Diversion Program, *Agenda Packet for May 27, 1998 Meeting* (Agenda Item V.F. regarding Facilitator Records) (on file at CPIL). None of these recommendations were ever discussed, reviewed, or ratified by DMQ at any public meeting.

[476] *See* 1982 Auditor General Report, *supra* note 427, at 36 ("the board has not established policies governing frequency of contact with participants"), 40 ("the board has not established policies for approving and monitoring supervised, structured environments for Diversion Program participants"), 43 (the board has failed to establish "standards and guidelines for terminating participants"). *See also* 1986 Auditor General Report, supra note 430, at 21 ("[t]he Board of Medical Quality Assurance has improved some elements of its diversion program for physicians; however, further improvement is needed. . . . [T]he board still does not routinely monitor physicians in the diversion program

clear: "The diversion program of the Board of Medical Quality Assurance does not protect the public while it rehabilitates physicians who suffer from alcoholism or drug abuse. . . . The medical board has allowed these problems to develop because it has not adequately supervised the diversion program."[477]

As described above, DMQ made an effort beginning in 1998 to reclaim its jurisdiction over the Diversion Program, and in 2000 established a standing Committee on the Diversion Program to meet quarterly to discuss Diversion-related issues. The Committee has done its best to fashion procedures to enable it to oversee the Program, including its review of "Quarterly Quality Review" reports on the Program's responses to intakes, relapses, and releases. However, the Committee remains at the mercy of staff in terms of the information that it receives — and at no time has staff apprized the Committee of any of the serious issues described above by the Monitor. The Committee has attempted to address a number of major issues, including the criteria for "evaluating physicians" (described above), the issue of "postgraduate tracking" of Diversion Program participants to determine the effectiveness of the Program (described below), and an important issue that has been raised at nearly every Committee meeting in the past four years but never addressed — what to do about self-referred physicians who clearly have serious addiction problems but are "not interested" and walk away. These issues — raised again and again, and referred to staff or the LCD for discussion — remained unresolved due to the volunteer nature of LCD, its infrequent meeting schedule and unclear agenda, and the Diversion Program's lack of staff.

The governance of the Diversion Program must be transformed into an accountable structure with a sufficient number of staff who are able and willing to implement DMQ's instructions, with monitoring mechanisms that provide DMQ with an ability to meaningfully oversee both staff and participant compliance with policies and procedures (preferably statutes and regulations) that it has approved and the Program's response to specific cases. If this structure is not possible, or if DMQ is unwilling to fully design and participate in it, then the Diversion Program should be abolished and the licenses of impaired physicians should be suspended until they prove that they are capable of safe medical practice.

4. The Diversion Program is isolated from the rest of the Medical Board; its management has not been consolidated into enforcement management or general MBC management.

As described in Chapter V above, the management of the Diversion Program is not well-integrated into overall MBC management. For many years, the Medical Board — both the Board

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adequately").

[477] *See* 1985 Auditor General Report, *supra* note 428, at 29.

and its staff — has permitted Diversion to effectively function in a vacuum. Considering the current confidentiality under which the Diversion Program operates, it is not unreasonable that the identities of self-referred Diversion Program participants be concealed from the enforcement program and from MBC management. However, the entire operation of the Diversion Program has been walled off from the rest of MBC management. This separation has resulted in breakdowns in key Diversion Program monitoring mechanisms described above — breakdowns that pose a risk not only to the public but also to the physicians participating in the Program, and which have not been communicated to MBC management so that management might address it. The Monitor has found several examples that illustrate this failure:

■ Our interviews with Diversion Program staff revealed that another "monitoring mechanism" utilized by the Diversion Program is the confiscation of drug prescribing permits issued by the U.S. Drug Enforcement Administration (DEA); these permits enable physicians to prescribe controlled substances. Program staff told us that when a Diversion Program participant is addicted to a controlled substance, the Program confiscates his DEA permit to preclude self-prescription of that drug; the physician turns the permit over to Diversion, which files it in a special file. Our review of twenty recent intakes revealed that three physicians had been required to turn their DEA permits over to Diversion; however, none of those permits were in the special file.

This is irrelevant, however, because the mere confiscation of a DEA permit does not prevent a physician from prescribing controlled substances. DEA permits are good for three years. Pharmacists continue to dispense controlled substances on the prescription of a DEA-permitted physician until the three-year term expires or until DEA revokes or restricts the permit and communicates that fact to pharmacies. Internet prescribing sites continue to dispense upon the physician's entry of a DEA permit number (for which the actual permit is unnecessary). And physicians may continue to order controlled substances in bulk directly from drug wholesalers. DEA issues the permit, and only DEA can revoke or restrict the permit. Unless DEA takes action against the prescriber's privileges, the physician can and will continue to self-prescribe controlled substances, purchase them on the Internet, or purchase them in bulk from drug wholesalers.

When MBC's enforcement program takes disciplinary action against a physician and, as one term of probation, restricts the physician's prescribing privileges, enforcement requires the physician to surrender the DEA permit *to DEA*, and to provide proof to MBC that DEA has accepted the surrender and cancelled or restricted the physician's prescribing privileges. However, the Diversion Program merely confiscates — or purports to confiscate — the DEA permit. That practice is inconsistent with MBC's *Disciplinary Guidelines* and its *Probation Operations Manual*; is probably unlawful in that it infringes on the authority of DEA and (in the absence of a Medical Board disciplinary order) only DEA can revoke or restrict DEA prescribing privileges; and is ineffective in preventing the physician from self-prescribing or purchasing controlled substances. However, the

Diversion Program does not know this because the Diversion Program is not sufficiently integrated into enforcement management or overall MBC management. This is unacceptable. For many Diversion participants, Diversion is a Board-ordered alternative to discipline. Diversion Program management should be well-versed in MBC's disciplinary program and procedures.

■ The *Diversion Program Manual* requires case managers to periodically check the enforcement program's CAS database for new complaints against Diversion Program participants.[478] However, the case managers have no access to CAS. Nor do they have access to the Department of Justice's CURES database to assess whether Program participants are prescribing medications in violation of their Diversion Agreements. The case managers are not investigators, the Program lacks investigative assistance, and sometimes the Program needs investigative assistance. This assistance is neither requested nor forthcoming because of the "firewall" between enforcement and the Diversion Program.

■ The Diversion Program has allowed its *Diversion Program Manual* to become almost completely obsolete. Most of its pages are dated in 1998. It fails to incorporate changes in Diversion Program statutes made by SB 2239 (Committee on Business and Professions) (Chapter 878, Statutes of 1998),[479] SB 1554 (Committee on Business and Professions) (Chapter 836, Statutes

[478] Medical Board of California, *Diversion Program Policy, Guidelines, and Procedures* (undated) ("Protocol for Checking the CAS System for Current Diversion Participants").

[479] SB 2239, which the *Manual* refers to as "pending" (page 9) amended section 2350 to require physicians participating in the Diversion Program to sign an agreement that Diversion Program records may be used in disciplinary or criminal proceedings if the participating is terminated from the Program and one of the following conditions exist: (1) his/her participation in the program is a condition of probation; (2) he/she has disciplinary action pending or was under investigation at the time of entering the Program; or (3) a DEC determines that he/she presents a threat to the public health or safety. The agreement must also authorize the Diversion Program to exchange information about the participant's recovery with a hospital well-being committee or monitor and with MBC's licensing program, where appropriate, and to acknowledge, with the participant's approval, that he/she is participating in the Diversion Program. SB 2239 also amended section 2355 to clarify that, if a Diversion Program participant successfully completes the Program, the Program will purge and destroy all treatment records pertaining to the physician's participation; however, the Program may retain any other information and records that it specifies by regulation. Although the Diversion Program has not amended its procedure manual to reflect the changes made by SB 2239, it has incorporated SB 2239's requirements into its standard participant agreement.

of 2000),[480] and SB 1950 (Figueroa) (Chapter 1085, Statutes of 2002).[481] As noted in Chapter V, the Diversion Program's manual is not alone in being out-of-date; however, it is the worst offender. Clearly, the Diversion Program has not been required — as have other MBC units — to regularly revise and update its policy and procedure manual. This is a critical management function that must be recognized, resourced, and regularly performed.

5. The Program's claim of a "74% success rate" is misleading.

The Diversion Program periodically calculates the total number of admissions into the Program, the total number of "successful completions," and the total number of "unsuccessful terminations." Based on this calculation, the Program advertises a "success rate." For example, in its March 2000 brochure, the Program announced that "[f]rom the inception of the Diversion Program in 1980 to March 1, 2000, there have been 981 participants. Six hundred sixty-three (663) of these have completed the program successfully. After factoring out physicians who did not complete for reasons unrelated to their disorders, this results in a 74 percent success rate."

This is misleading. While it appears to convey effectiveness in assisting participants to recover from substance abuse, it means only that 663 physicians completed the program and were "successfully terminated." The Diversion Program does no postgraduate tracking of its participants — either successful or unsuccessful — in any way, so it has no information on whether those physicians are safely practicing medicine, whether they have relapsed into unmonitored drug/alcohol use, or whether they have died from it. The Program has no idea whether it is successful in rehabilitating physicians over the long term. In fact, of the twenty recent intake cases we reviewed, three had previously "successfully completed" the Diversion Program. At the very least, Diversion

[480] SB 1554, an outgrowth of the work of the 1998 Diversion Task Force, amended numerous sections of the Diversion Program's statutes to clarify that DECs act in an advisory capacity only to the Diversion Program Manager. Significantly, the manual has not been updated to reflect the law's clarification that DECs act in an advisory capacity only. In Chapter 1 alone, there are 11 references to the DECs' "decisions" or "determinations." SB 1554 also amended section 2350(g) to extend the minimum period of time a physician must remain free from the use of drugs/alcohol from two to three years in order to successfully complete the Diversion Program; repealed a requirement that DECs hold public meetings twice a year (with which the DECs were noncompliant) and instead requires them to provide specified information to the Board; and requires the Board to hold a public meeting at least annually for the purposes of reviewing the data provided by the DECs.

[481] SB 1950 amended section § 2350(b) to permit mentally ill physicians to be "diverted" into the Diversion Program; added section 2350(g)(2) to establish criteria for successful completion of the Diversion Program by mentally ill physicians; amended section 2350(h) to require DMQ to establish criteria for selecting "evaluating physicians or psychologists" who evaluate prospective Diversion Program participants upon application to the Program; and added a new paragraph to section 2350(j)(3) that allows the Diversion Program, upon recommendation by a DEC, to order a participant to undergo a clinical competency exam. Failure of the participant to comply with this order is grounds for license suspension/revocation. The amendment also requires "the board" to "develop regulations that provide guidelines for determining when this examination should be ordered." The Diversion Committee and Liaison Committee are in the process of drafting these regulations.

Program claims should contain careful explanations of terms like "success" to avoid misleading the public.

The Monitor has occasionally heard Program staff and supporters make statements to the effect that "no patient has ever been injured by a physician in the Diversion Program." This is similarly misleading. Injury to patients is not a type of information that the Program captures or publicizes. As demonstrated above, the Program does not even know whether its participants are being drug-tested as frequently as its own policies require, or whether they have adequate worksite supervision, or whether their treating psychotherapists are properly reporting on their patients' progress. As described above, at least one participant almost died due to the failure of the Program's urine testing program. Published news articles prove that injury to patients — if it has not already occurred — is a tragedy waiting to happen.[482] The Program should be less concerned with "spin" about its effectiveness and more concerned about real-time monitoring of impaired physicians to protect the public.

H. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #56: Based on the information contained in this and prior reports on the Diversion Program, the Medical Board must reevaluate whether the "diversion" concept is feasible, possible, and protective of the public interest. The Medical Board's paramount priority is public protection. It is unclear why a board charged with public protection as its paramount priority would permit physicians who are addicted to drugs or alcohol to practice medicine before they have recovered from that addiction. If such a board believes that impaired but recovering physicians should be permitted to practice medicine while they are in recovery and susceptible to relapse, that board must insist on comprehensive monitoring mechanisms which are demonstrably effective in detecting both relapse and pre-relapse behaviors, to protect both the participant and the public at large. According to the clear findings in three Auditor General reports and this report, this Board's Diversion Program has never consistently — if ever — had those monitoring mechanisms in place in all cases and at all times, thus exposing the public to unacceptable risk in violation of Business and Professions Code sections 2001.1, 2229, and 2340. The Medical Board must determine whether it is possible to develop, resource, and ensure the effective monitoring mechanisms demanded by state law, or whether the public interest demands that the licenses of impaired physicians be suspended during periods of impairment.

Recommendation #57: If the Board determines that it is possible to implement the "diversion" concept consistent with the public interest (which is presently demanded by

[482] *See, e.g.*, David Washburn and David Hasemyer, *Substance Abuse Program Criticized as Full of Loopholes*, S.D. UNION-TRIB., Mar. 11, 2002.

sections 2001.1, 2229, and 2340), the Board must then determine whether to house that diversion program within the Medical Board or contract it out to a private entity. This Board has evaluated that question on several occasions (most recently during its 2002 strategic planning session), and has determined to preserve the Program within the Medical Board. However, the Board did not have access to the findings in this report at that time. Nor did it have full and objective information on the alternative structures currently used by other California regulatory agencies — because it has insufficient staff to research that question and present that information to the Board. The Board must undertake an informed and objective study of all other models used by other state medical boards and other California agencies with diversion programs.[483]

Presumably, the current location of the Diversion Program within the Medical Board was intended to enable the Board — and specifically, its Division of Medical Quality — to comprehensively oversee and supervise the functioning of the Program. As demonstrated above, that goal has not been realized thus far. Undeniably, the location of the Diversion Program within the Medical Board may discourage some physicians from self-referring into Diversion because they are afraid of possible referral to enforcement if they fail. The location of the Diversion Program within the Medical Board may be deterring physicians who would otherwise seek help from seeking help — the antithesis of the purpose of the Program. On the other hand, contracting out the administration of the Program would give the Board less access to and control over the precise details of its operations. This is a decision that the Board must make — fully informed by the findings in this report, the reports of the Auditor General, and a complete study of the diversion program models used by other state medical boards and other California agencies.

Recommendation #58: If the Medical Board decides that "diversion" is feasible and that administration of the Diversion Program should remain within the Medical Board, the Division of Medical Quality must spearhead a comprehensive overhaul of the Diversion Program to correct longstanding deficiencies that limit the Program's effectiveness both in terms of assisting participant recovery and in terms of protecting the public. This overhaul must include an influx of staff resources (including — at the very least — the addition of a manager to supervise the case managers, a sufficient number of case managers so their caseloads never exceed 50 cases, and a full-time Collection System Manager whose entire job is devoted to ensuring the integrity of the Program's urine collection system) and the installation and staffing of internal quality

[483] For example, the Board of Pharmacy — in addition to contracting out the administration of its diversion program — does not use regional DECs to make recommendations on individual cases. Information on applicants and participants who have relapsed is forwarded to one single "Pharmacy Review Committee" consisting of a manager from the private company which administers the Board's Diversion Program, a supervising inspector, and the Board's Diversion Program Manager. That one committee makes all decisions, rather than farming them out to five different regional DECs which meet only quarterly. Throughout this chapter, the Monitor has identified other mechanisms utilized by other state medical boards and their Diversion Programs of which this Board should take note. Those mechanisms have never been studied or debated by DMQ or the Diversion Committee.

controls to assure the Division, Program participants, and the public that the Program's monitoring mechanisms are effective in detecting relapse into drug/alcohol use. The restructuring must also include the long-overdue adoption by DMQ of meaningful criteria for acceptance, denial, and termination from the Diversion Program, and standards for the Program's response to relapse (see Recommendation #62 below). If the Division adopts clear standards applicable to relapse and termination from the Program, it may be that significant staffing additions are unnecessary because noncompliant participants will be terminated from the Program more quickly.

Recommendation #59: The Division of Medical Quality must reclaim its authority and jurisdiction over the Diversion Program by abolishing the Liaison Committee as it is currently structured. Consistent with its comprehensive restructuring of the Diversion Program in Recommendation #58 above, the Division must determine whether there is a need for external clinical expertise and — if so — convert the Liaison Committee into a workable advisory panel that serves the needs of DMQ as determined by DMQ. The LCD has evolved into an unwieldy 19-member committee whose members have not been chosen by DMQ, whose purpose is unclear, and whose output is modest and excessively delayed. Over the years, the Liaison Committee has taken, or has been delegated, responsibility for addressing important issues which have not been promptly (or ever) resolved. The skills, expertise, and time of Liaison Committee members could be better directed to a different function as determined by the Division of Medical Quality.

Recommendation #60: The Division of Medical Quality must determine whether Program participation should be an "entitlement" for any and all impaired California physicians, or whether its participation should be capped at a maximum that can meaningfully be monitored by the staff allocated to the Diversion Program. This report has outlined the staffing constraints that currently plague the Diversion Program, and the impacts of those staffing constraints on its ability to monitor participants and protect the public. Even the Program has recognized that it cannot simply keep accepting more participants. DMQ must decide how the Program is to be structured and funded. If Program participation must be capped, the Division must further consider who should have priority — Board-ordered participants, Board-referred participants who enter under a statement of understanding with the enforcement program, or self-referred physicians.

Recommendation #61: Regardless of whether Diversion Program participation is deemed an entitlement or is capped to accommodate staffing and protect the public, the Diversion Program's budget should be earmarked and separated from other MBC program budgets. The Diversion Program should be funded by a specified and identifiable portion of MBC license fees paid by all California physicians, and by participation fees paid by participants (as is done at the Dental Board, the Pharmacy Board, and the Board of Registered Nursing). The Monitor believes that all Program participants who can afford to pay participation fees — including all participants who are practicing medicine — should pay them. In particular, the Monitor agrees with

the Auditor General's 1995 recommendation that physicians who are ordered to participate in the Diversion Program as a term of probation should pay their proportionate share of the overhead costs of the Program — as do MBC probationers who are currently required to pay $2,800 per year for their probation monitoring costs. Indigent physicians who are so impaired that they are unable to work should not have to pay participation fees. In 32 states, physician diversion programs are funded by a combination of physician license fees, monthly participation fees paid by participants, and contributions from the state medical society. Other states require contributions from malpractice carriers and hospitals as well. DMQ should research and evaluate the feasibility of supplementing the budget of its Diversion Program through these sources.

Recommendation #62: DMQ must establish enforceable standards and consistent expectations of participants and Diversion Program staff through legislation or the rulemaking process, oversee a comprehensive revision of the Diversion Program's policy manual, and ensure that Diversion Program management is integrated into overall MBC management. The Monitor recommends that DMQ consider enforceable standards in a number of areas:

- First, to address the repeated "bites of the apple" problem and prevent chronic relapsers from consuming Program resources, DMQ should consider adopting a "deferred entry of judgment" mechanism similar to that in Penal Code 1000. Under that type of mechanism, an applicant for admission to Diversion would sign an agreement in which he admits to a violation of section 2239 (self-abuse of drugs or alcohol) and stipulates to the revocation of his license. That judgment would be "deferred" during participation in the Diversion Program. If the participant successfully completes the Program, that admission would be destroyed. If the participant is unsuccessfully terminated, that admission could be used against him in subsequent disciplinary proceedings. Pennsylvania uses this type of mechanism.[484]

- Alternatively, the Division should consider banning Diversion Program participation to anyone who was previously a participant in the Program pursuant to an SOU, a stipulation, or Board-ordered probation within a specified number of years and who failed to successfully complete the Program.

- In adopting criteria for termination from the Program, the Division should consider adopting in regulation the Program's current "three-strikes-and-you-may-be-out" policy (which is arguably underground rulemaking). If such a policy is adopted, the participant could be referred to the DEC for consideration of termination or, if the Division believes faster action is necessary to protect the public, it could delegate the decision to the Program Administrator without DEC consideration.

[484] 63 P.S. § 422.4(c).

■ The Monitor also recommends that the Division consider a required (or at least presumed) "cease practice" period at the commencement of Program participation to enable a full-scale interdisciplinary evaluation of the extent of the physician's addiction, afford time for necessary treatment, and encourage the physician to focus on recovery. New York requires a physician participant to temporarily surrender his/her license upon entry into its diversion program.[485] Similarly, the California Board of Registered Nursing requires a cease practice period at the beginning of participation in its Diversion Program; DEC approval is required before the nurse may return to work.

Additionally, DMQ must ensure that the *Diversion Program Manual* is completely rewritten to incorporate the impact of all relevant statutory and regulatory changes. And MBC management must effectively integrate and incorporate Diversion Program management into overall Board and enforcement program management, to ensure that Diversion staff are knowledgeable of enforcement procedures which impact its Board-ordered participants.

Recommendation #63: DMQ should explore various methods of assessing the long-term effectiveness of the Diversion Program in assisting physicians in recovering from substance abuse. Such an assessment would provide invaluable information and enable informed decisionmaking to guide future Diversion Program structure and operations.

Recommendation #64: The Medical Board should continue its efforts to replace and upgrade the Diversion Tracking System. As discussed in Chapter V.A., Program staff believe the DTS is obsolete even though it is only three years old. The Monitor found numerous errors and gaps in the DTS which were unknown to Program staff, mostly stemming from the lab's download of incorrect urine testing information and DTS' failure to post lab test information to the correct participant's file.

Recommendation #65: The Medical Board's Diversion Program should undergo a full performance audit by the Bureau of State Audits every five years. Under no circumstances should 18 years pass between external performance audits of this critically important program which is permitted to operate in secrecy.

[485] N.Y. PUB. HEALTH LAW § 230(13)(a).